

**Semi-Annual Report to the  
Joint Legislative Oversight Committee  
on Mental Health, Developmental Disabilities and Substance Abuse Services**

**Mental Health, Developmental Disabilities and Substance Abuse Services  
Statewide System Performance Report  
SFY 2008-09: Spring Report**

**Session Law 2006-142**

**House Bill 2077**

**Section 2.(a)(c)**

**April 1, 2009**

**North Carolina Department of Health and Human Services  
Division of Mental Health, Developmental Disabilities and Substance Abuse Services**

## **Executive Summary**

Legislation in 2006 (Session Law 2006-142, HB 2077 Section 2.(a)(c)) requires the Division of Mental Health, Developmental Disabilities and Substance Abuse Services to report to the Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) every six months on progress made in seven statewide performance domains. This semi-annual report builds on the measures in the previous reports.

Domain 1: Access to Services – The system measures the number of individuals actually receiving services against the number of individuals projected to have a mental illness, developmental disability or substance use disorder based upon national prevalence rates. Among all the age-disability groups, a greater percentage of children estimated to have a mental illness are receiving services. Almost half (47%) of children estimated to have a mental illness are provided services by the public system compared to 40% of adults projected to have a mental illness. Only 20% of children estimated to have developmental disabilities and 37% of adults estimated to have developmental disabilities are provided services by the public system. The few services provided to persons projected to have substance abuse problems (less than 10% of those estimated to be in need for both adolescents and adults) continues to be an area of significant concern. Over the past two calendar years, the timeliness of initial services for routine care has improved, increasing from 60% to 67%. The Division expects the current economic environment to bring more people to the public system, increasing the number of new requests for care, while current budget restrictions will make it more difficult for the public system to provide timely care to all those who need help.

Domain 2: Individualized Planning and Supports – Consumers with mental health and substance abuse disorders (regardless of age-disability group) overwhelmingly report having a choice in their provider. The large majority of consumers with developmental disabilities report having some input in how they spend their day, money and free time (very similar to consumers in all participating states). In addition, the majority of consumers with developmental disabilities report they know their Case Managers and their Case Managers are supportive and accessible. For mental health and substance abuse consumers, the large majority of children and adolescents report family involvement in planning and treatment but this is not the case for adult consumers.

Domain 3: Promotion of Best Practices – The beginnings of an array of tiered Medicaid waivers was implemented in November 2008 for persons with developmental disabilities, providing an opportunity to enhance best practice approaches to delivering these consumers' services and supports. For mental health and substance abuse consumers, the last several quarters have shown significant decreases in the use of the community support service and corresponding increases in the availability of a wider array of best practice services for both child and adult consumers.

Domain 4: Consumer-Friendly Outcomes – North Carolina consumers with developmental disabilities report strong participation in community life such as shopping, entertainment, going out to eat and running errands (very similar to reports from consumers in all other states). Over one-third of mental health and substance abuse consumers report that services have helped them improve their education, housing, and employment (although, in most circumstances, adult substance abuse consumers report more improvement than the other groups).

Domain 5: Quality Management Systems – As part of the continuing effort to gain control of the inappropriate overuse of the community support service, almost 600 providers were terminated during 2008, primarily for billing inactivity and/or withdrawal of endorsements by Local Management Entities (LMEs). In addition, the Division has implemented statewide tools and processes for monitoring providers and LMEs. The NC-TOPPS consumer outcomes system has undergone a number of

improvements and has implemented an online dashboard<sup>1</sup> to provide consumer outcome information to the public and interested stakeholders.

Domain 6: System Efficiency and Effectiveness – LMEs’ timely and accurate submission of information to the Division has improved over the last two calendar years, increasing from 66% at the beginning of 2007 to 79% at the end of 2008. By the end of the second quarter of SFY 2009, the LMEs used 51% of their state allocations for services as expected. Statewide, the percent of funds expended in the first six months of SFY 2009 varied from a high of 61% for child developmental disability services to a low of 8% for adolescent substance abuse services. Thirteen LMEs have received single stream funding for all of SFY 2009. As of January, only five have reported the expected volume of services as “shadow claims.” The Division has implemented criteria for continued eligibility for single-stream funding, which includes reporting at least 85% of funding as shadow claims.

Domain 7: Prevention and Early Intervention – In October 2008, North Carolina implemented the Statewide Abuse Prevention Program Monitoring and Evaluation System, known as *North Carolina Prevention Outcomes Performance System (NC-POPS)*. All provider agencies contracted by LMEs to provide prevention services have full access to the system free of cost. Providers are expected to do their annual planning utilizing the system and also document information on the prevention programs and services they provide, including tracking Synar compliance and National Outcome Measures (NOMs) on the consumers served.

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<sup>1</sup> The online dashboard can be accessed by going to the NC-TOPPS homepage at <http://www.ncdhhs.gov/mhddsas/nc-topps/> and clicking on the icon “*Outcomes at a Glance*”.

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# **Mental Health, Developmental Disabilities and Substance Abuse Services**

## **Statewide System Performance Report**

### **SFY 2008-09: Spring Report**

#### **Introduction**

The *Mental Health, Developmental Disabilities and Substance Abuse Services Statewide System Performance Report* is presented in response to Session Law 2006-142, Section 2.(a)(c)<sup>2</sup> and builds on the measures reported in previous semi-annual reports.

Since the October 2008 report the Division has taken the following actions to improve the performance of the service system:

- Standardized tools and processes for assessing provider risk and monitoring provider quality were developed through state-local collaboration and implemented statewide.
- Standardized tools and processes for assessing LME risk and monitoring their implementation of contracted requirements have been developed and are currently being piloted.
- Two new formats for communicating performance data, “*Critical Measures at a Glance*” and “*Outcomes at a Glance*,” provide the public, system managers, and legislators with easily accessible information on local and statewide system effectiveness.<sup>3</sup>
- The Division has created a Knowledge Management Group to review service system data regularly to identify emerging problems and opportunities, in keeping with recommendations from the General Assembly’s Program Evaluation Department and the Institute of Medicine’s Substance Abuse Taskforce.
- Simplification of the Integrated Payment and Reporting System (IPRS) reimbursement rules and extension of single-stream funding to 13 of the 24 LMEs has increased opportunities for flexible use of state funds.
- Initiation of an electronic health record system in Central Regional Hospital with plans for expansion to other state facilities and the community service system begins the process of integrating data systems across the state to enhance coordination of care and cost-effective management of system performance.

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<sup>2</sup> See Appendix A for specific legislation.

<sup>3</sup> The “Critical Measures at a Glance” can be accessed on the Division’s website through the following link: <http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm>. The “Outcomes at a Glance” can be accessed through the Division’s website through the following link: <http://www.ncdhhs.gov/mhddsas/nc-topps/index.htm>.

## Domains and Measures of Statewide System Performance

The domains of performance written into legislation reflect national consensus on goals all states should be working toward, specifically to provide support for individuals with disabilities to be able to live productive and personally fulfilling lives in communities of their choice. The Division continues to refine performance measures to evaluate the implementation of system reform efforts and its impact on system performance and consumers' lives. The Division's measures relate to:

- The goals of *The State Strategic Plan: 2007-2010*.
- SAMHSA National Outcome Measures (NOMS)<sup>4</sup>
- Areas of quality recommended in the CMS Quality Framework<sup>5</sup>
- Performance requirements specified in the *SFY 2009 DHHS-LME Performance Contract*.

The performance measures chosen for this report to the Joint Legislative Oversight Committee are a result of continuing work in this effort. For each performance area, the following sections include:

- A description of the domain.
- A statement of its relevance to system reform efforts and importance in a high-quality system.
- One or more measures of performance for that domain, each of which includes:
  - A description of the indicator(s) used for the measure.
  - The most recent data available and an explanation of trends and patterns in the data.
  - Division expectations about future trends and plans for addressing problem areas.

Appendices at the end of this report provide information on the data sources for the information included in each domain.

### **Domain 1: Access to Services**

Access to Services refers to the process of entering the service system. This domain measures the system's effectiveness in providing easy and quick access to services for individuals with mental health, developmental disabilities and substance abuse service needs who request help. Timely access is essential for helping to engage people in treatment long enough to improve or restore personal control over their lives, and to prevent crises. Both the SAMHSA National Outcome Measures and CMS Quality Framework include measures of consumers' access to services.

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<sup>4</sup> See Appendix B for details.

<sup>5</sup> See Appendix C for details.

## Measure 1.1: Persons Receiving Community Services

National research estimates the occurrence of chronic and serious mental health, developmental disabilities and substance abuse problems in the population (*prevalence*). (See Appendix D for sources.) Based on the most recent estimates,<sup>6</sup> every year:

- Approximately 12% of children and adolescents (ages 9-17) and 5.4% of adults (ages 18 and older) face serious mental health (MH) problems. Although no estimates for children under age 9 have been established, studies include estimates ranging from 11% to 18%.<sup>7</sup>
- Prevalence rates for developmental disabilities (DD) vary across age groups and decrease as the population ages. According to national estimates, the prevalence rates are as follows: ages 3-5 = 3.8%; ages 6-16 = 3.2%; ages 17-24 = 1.5%; ages 25-34 = 0.9%; ages 35-44 = 0.8%; ages 45-54 = 0.7%; ages 55-64 = 0.5%; ages 65 and older = 0.4%.
- Approximately 7.83% of adolescents (ages 12-17), 18.87% of young adults (age 18 to 25), and 6.84% of older adults (age 26 and above) face serious substance abuse (SA) problems.

Applying these estimates to North Carolina's populations translates into almost 350,000 NC adults needing mental health (MH) services and almost 565,000 needing substance abuse (SA) services each year. Approximately 51,000 adults need services and supports for a developmental disability (DD).<sup>8</sup>

Assuming the 12% prevalence rate for older youth (ages 9-17) also applies to children under age 9, approximately 204,000 children experience MH problems each year that, if not addressed, can lead to a MH disorder. Almost 55,000 children and adolescents (ages 0-17) in North Carolina have a developmental disability and another 53,000 adolescents (ages 12-17) experience a diagnosable SA disorder.

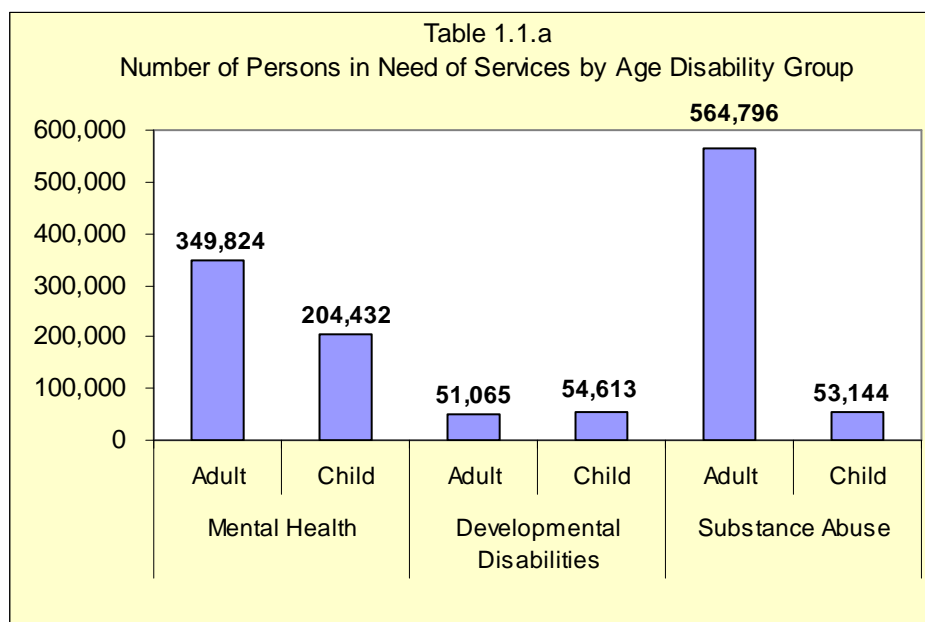
The Division is committed to serving individuals with mental health, developmental disabilities, and substance abuse needs in their communities rather than in institutional settings. Tracking the number of persons in need who receive community-based services (*treated prevalence*) through the public MH/DD/SAS system provides a barometer of progress on that goal.

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<sup>6</sup> These estimates are updated regularly to reflect the most recent information provided by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and research on developmental disabilities. See the Appendix D for source information.

<sup>7</sup> The Division applies the estimates established for ages 9-17 to all children ages 0-17 to estimate the numbers of North Carolina children and adolescents in need of mental health services. See Appendix D for more information.

<sup>8</sup> The numbers presented here include all persons in North Carolina estimated to need mh/dd/sa services, including those who may be served by private agencies or other public systems.



SOURCE: Office of State Budget and Management (OSBM) State Demographics Unit, June 2008 population projection data.

Not all persons in need of MH/DD/SA services will seek help from the public system. Those who have other resources, such as private insurance, will contact private providers for care. However, many – especially those with mental health and/or substance abuse issues – will not seek help at all, due to a lack of knowledge of what services are available or how those services can help. In addition, cultural stigmas against admitting problems and distrust of governmental programs keep others from seeking help.<sup>9</sup>

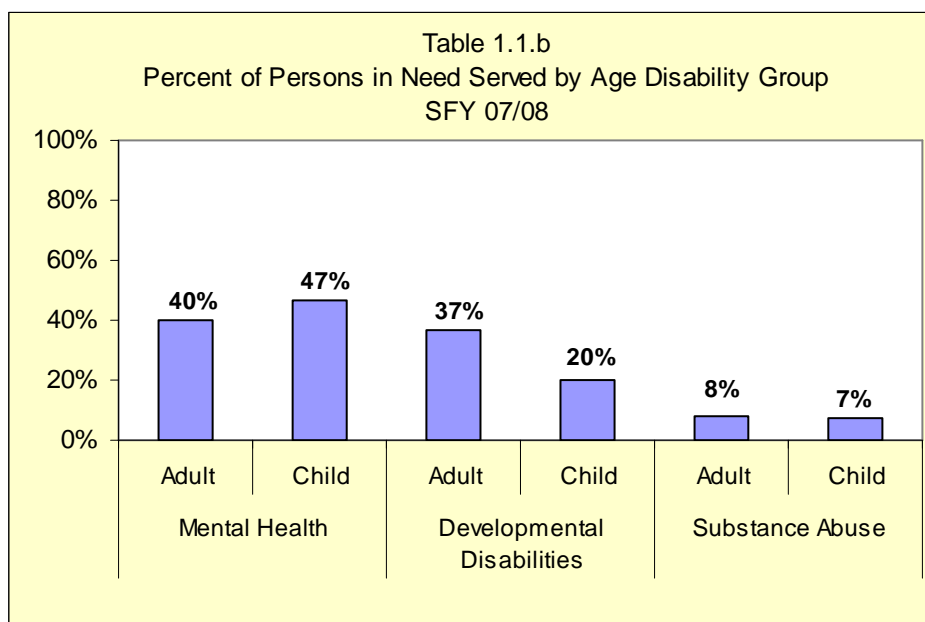
Table 1.1.b presents the percent of persons estimated to be in need who received publicly-funded community-based services during the last state fiscal year.<sup>10</sup> This percentage provides information that the Division uses to establish reasonable targets and to evaluate the need for future changes to fiscal or programmatic policies.

As seen in Table 1.1.b., the state's public system serves only 8% of adults estimated to have substance abuse disorders compared to 40% of adults estimated to have mental health disorders and 37% of adults with developmental disabilities. This is, in part, a reflection of the larger percentage of individuals with mental health disorders and developmental disabilities who are Medicaid-eligible than the percentage of Medicaid-eligibility of individuals with substance abuse disorders.

<sup>9</sup> The Division of MH/DD/SAS is charged with serving persons ages 3 and above. The Division of Public Health is responsible for all services to children from birth through age 2. Local educational systems are responsible for educational services to children with developmental disabilities through age 21. The LME Administrative Cost Model, developed by Anthony Broskowski and used as a basis for LME funding, assumes that 48% of adults and 40% of children in need will be served through the public MH/DD/SAS system. The Division's current contract standards vary from expecting 8% of adults with substance abuse problems to 36% and 38% of adults with developmental disabilities and mental illness respectively to require public community services. Standards regarding children and adolescents are lower.

<sup>10</sup> The number of persons in need of services (the denominator) includes North Carolinians that the state's MH/DD/SA service system is responsible for serving (ages 3 and over for MH and DD, ages 12 and over for SA).





SOURCE: Medicaid and State Service Claims Data. July 1, 2007 - June 30, 2008.

The state serves 47% of children and adolescents (ages 3-17) estimated to need mental health (MH) services and 20% of children and adolescents (ages 3-17) estimated as needing developmental disabilities (DD) services. Approximately 7% of adolescents (ages 12-17) projected to be in need of substance abuse (SA) services receive them through the state's MH/DD/SA service system.

The Division has worked with the North Carolina Institute of Medicine over the past year to identify new strategies to improve access and engagement of individuals in need of substance abuse services. Recommendations include increasing funding for prevention activities, workforce development, and reduction of college drinking; increasing tobacco and malt beverage taxes; and developing performance-based incentives to improve services. (See <http://www.nciom.org> for the full report.)

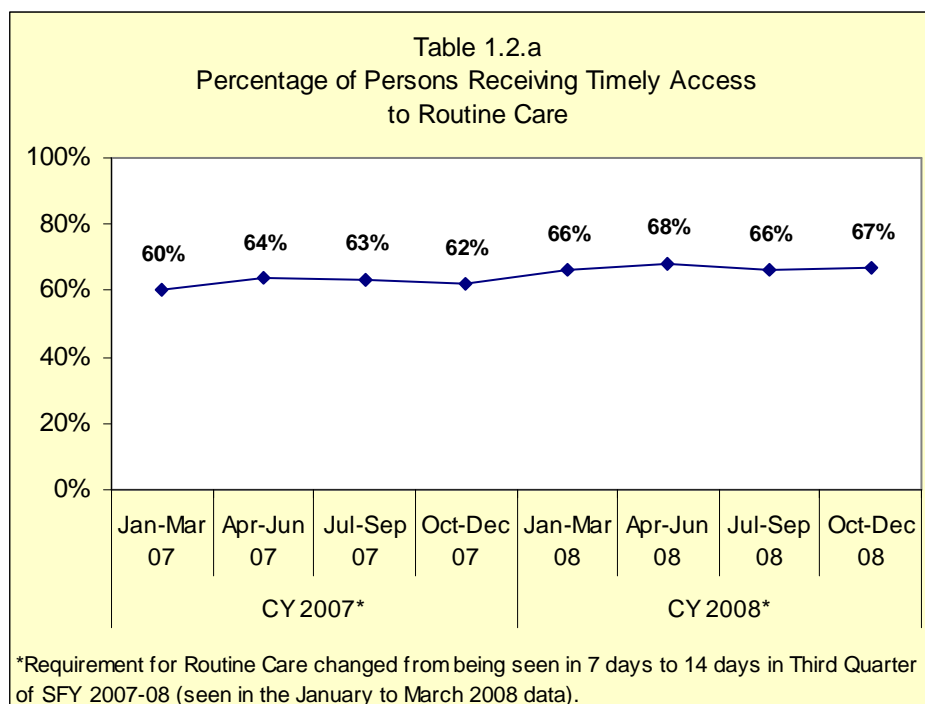
The Division is focused on improving services to individuals currently served in the public system, while increasing access to others who need services. The current economic environment will likely bring more people to the public system, increasing the number of new requests for care. At the same time, budget restrictions may make it more difficult for the public system to provide a sufficient level of care to all those who need help. **The Division expects an increase in the number of persons served over the coming year, which may come at the expense of timely and continued care.**

## Measure 1.2: Timeliness of Initial Service

Timeliness of Initial Service is a nationally accepted measure<sup>11</sup> that refers to the time between an individual's call to an LME or provider to request service and their first face-to-face service. A system that responds quickly to a request for help can prevent a crisis that results in more trauma to the individual and results in more costly care for the system. Responding when an individual is ready to seek help also supports his or her efforts to enter and remain in services long enough to have a positive outcome.

<sup>11</sup> Health Plan Employer Data and Information Set (HEDIS©) measures.

Table 1.2.a shows an increase in the percentage of consumers who seek routine (non-urgent) care and are actually seen by a provider within fourteen days of requesting services (an increase from 60% to 67% over the past two calendar years).<sup>12</sup> The percent of those who are seen within two hours in emergency situations and within 48 hours in urgent situations is even higher, at approximately 97% and 79% respectively (not shown).

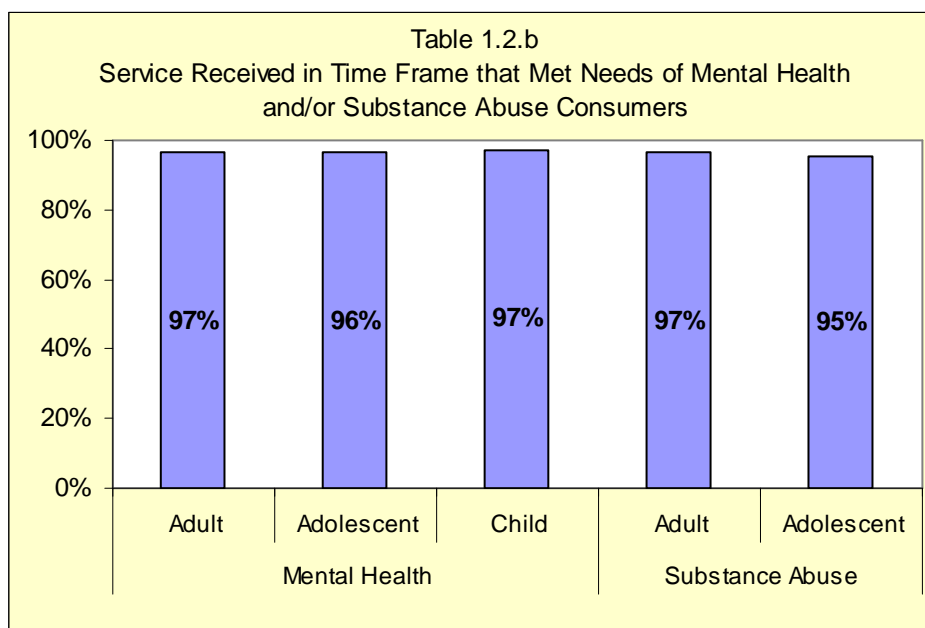


SOURCE: Data from LME screening, triage, and referral logs submitted to the NC Division of MH/DD/SAS as part of DHHS-LME Performance Contract.

While there has been some improvement in access to routine services, the Division continues to work with LMEs to reach the established goal of having 85% of consumers receive their first services in a timely fashion.

As shown in Table 1.2.b, almost all mental health and substance abuse consumers (regardless of age group) reporting outcomes data in SFY 2007-08 stated that services were received in a time frame that met their needs.

<sup>12</sup> The Division has historically measured timeliness of routine service as being seen within seven days of request. However, HEDIS considers a routine service as timely if delivered within 14 days of request. The *SFY 2008 DHHS-LME Performance Contract* adopted the HEDIS timeframe for requirements of LMEs. Beginning in the third quarter of SFY 2007-08 routine services presented herein uses the HEDIS 14-day timeline. This change has lowered the bar somewhat, thereby increasing the percent of persons for whom expectations of timely routine services are met.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS)  
Data. Initial Assessments conducted July 1, 2007 - June 30, 2008.

Due to expected increases in people seeking publicly funded services coupled with budget cuts in funding of services, the Division expects future reports to show a decreased percent of consumers meeting the standard for timely access, as LMEs and providers try to balance competing goals of serving increased numbers of people and providing timely and sufficient services to those who need help.

## ***Domain 2: Individualized Planning and Supports***

Individualized Planning and Supports refers to the practice of tailoring services to fit the needs of the individual rather than simply providing a standard service package. It addresses an individual's and/or family's involvement in planning for the delivery of appropriate services. Services that focus on what is important to the individual – and their family, where appropriate – are more likely to engage them in service and encourage them to take charge of their lives. Services that address what is important for them produce good life outcomes more efficiently and effectively.

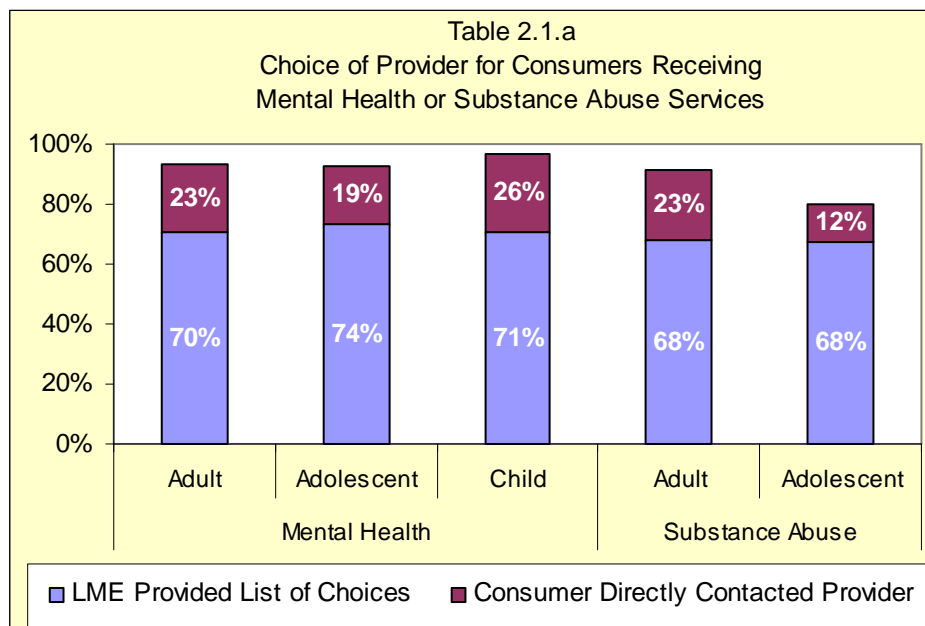
The CMS Quality Framework encourages measuring the extent to which consumers are involved in developing their service plans, have a choice among providers and receive assistance in obtaining and moving between services when necessary.

### **Measure 2.1: Consumer Choice**

Offering choices is the initial step in honoring the individualized needs of persons with disabilities. The ability of a consumer to exercise a meaningful choice of providers depends first and foremost on having a sufficient number of qualified providers to serve those requesting help.

**Consumers with Mental Health and Substance Abuse Disabilities (Table 2.1.a):** Finding the right provider can mean the difference between willing engagement in services or discontinuation of services before recovery or stability can be achieved. With sufficient provider capacity, consumers have an opportunity to select services from agencies that meet their individual scheduling and transportation requirements, address their individual needs effectively and encourage them in a way that feels personally comfortable and supportive.

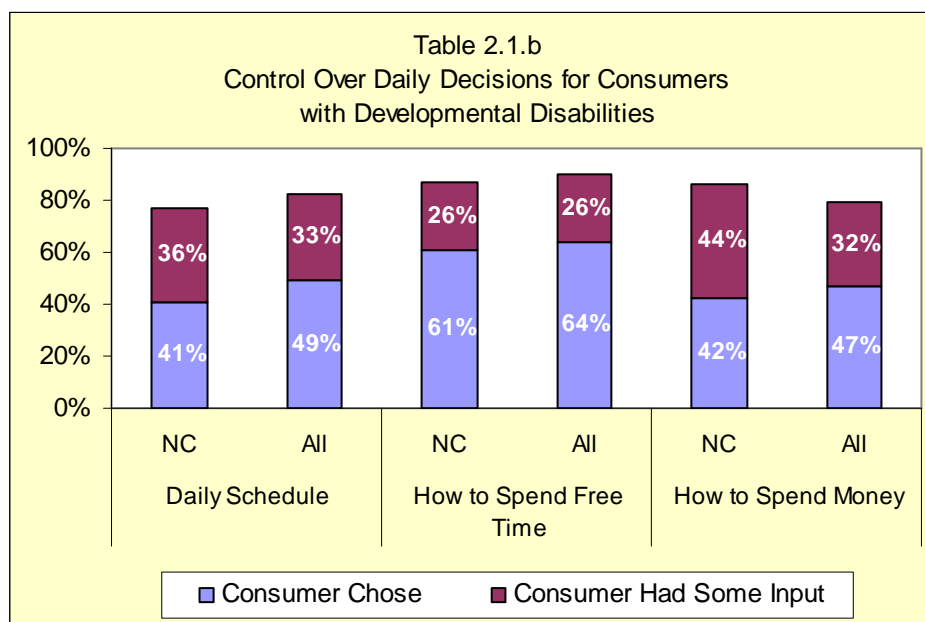
About three-fourths of mental health consumers (regardless of the age group) and two-thirds of adult substance abuse consumers reporting outcomes data in SFY 2007-08 said that the LME gave them a list of providers from which to choose services. Among all the age-disability groups, adolescent mental health consumers were most likely to report being provided a list of choices (74%). (See Appendix D for information on NC-TOPPS).



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2007 - June 30, 2008.

**Consumers with Developmental Disabilities (Table 2.1.b):** Having a choice of providers, while important, is not the only component of control consumers seek. Having control of one's life also requires being able to exercise choice in making both major and routine life decisions.

In SFY 2006-07 interviews, an overwhelming majority of consumers with DD reported choosing or having some input in how they spend their day (77%), free time (87%), and money (86%). Overall, there was very little difference between North Carolina consumers and consumers from all states participating in the project. (See Appendix D for more information on this survey.)



SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2006-07, North Carolina (NC) compared to All Participating States (All).

The Division expects a continuation in the current positive patterns of choice, as stabilization in the number of Community Support Providers coupled with a growth of other types of service providers, as discussed in Measure 3.1, improves the availability of appropriate choices available to consumers.

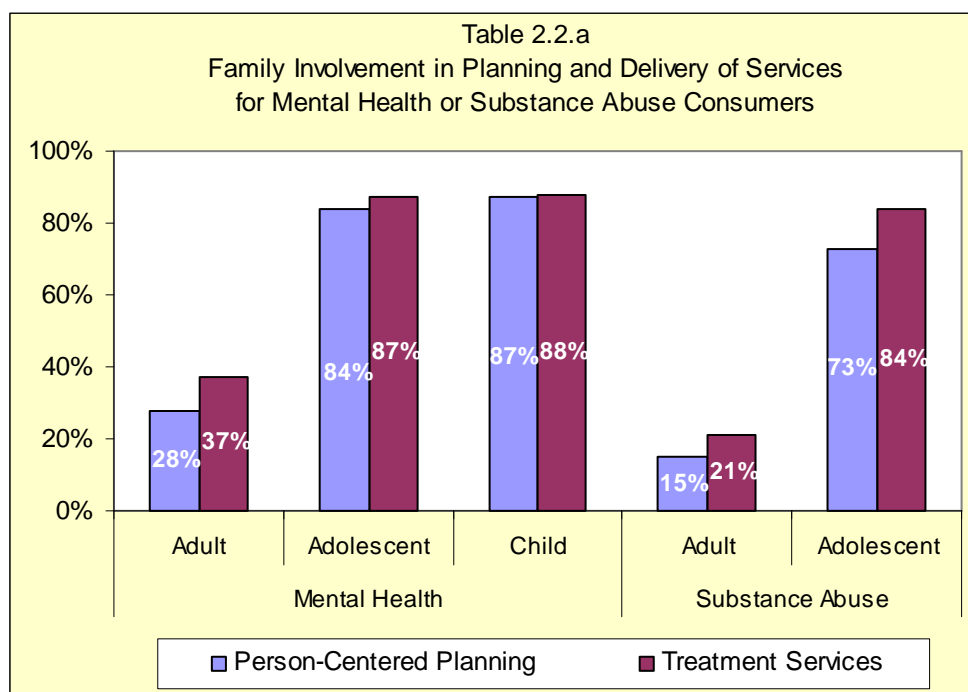
## Measure 2.2: Person-Centered Planning

A Person-Centered Plan (PCP) is the basis for individualized planning and service provision. It allows consumers and family members to guide decisions on what services are appropriate to meet their needs and goals and tracks progress toward those goals. The Division requires a PCP for individuals who receive publicly-funded community intervention services and developmental disability services and has implemented a standardized format and conducted training to ensure statewide adoption of this practice.

As the following tables show, a large majority of consumers are involved in the service planning and delivery process.

**Consumers with Mental Health and Substance Abuse Disabilities (Table 2.2.a):** Table 2.2.a, on the next page, shows that the overwhelming majority of families of children and adolescents with mental health disorders are involved in service planning and delivery. For families of adolescents with substance abuse disorders, almost three-fourths (73%) are involved with service planning and 84% are involved with service delivery. In contrast, relatively few adult consumers report their families being involved in planning or service delivery processes. Just under two-thirds (63%) of adult MH consumers reported family involvement in service delivery compared to four-fifths (79%) of adult SA consumers. Although not shown on the graph, almost three-fourths (74%) of the families of adult SA consumers and over half

(57%) of the families of adult MH consumers had no involvement in the planning of services or the delivery of services.<sup>13</sup>

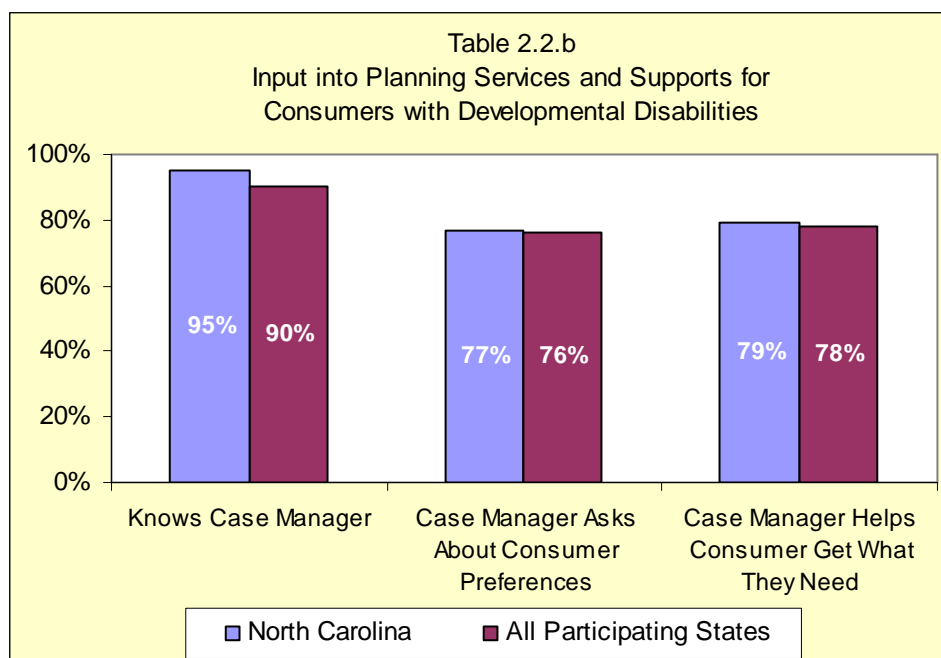


SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS)  
Data. 3 Month Update Interviews conducted July 1, 2007 - June 30, 2008

The greater involvement of parents of children and adolescents may reflect the state's efforts to institute a system of care that strongly encourages family ownership of service planning and delivery. In contrast, adult consumers are often reluctant to involve family members in their treatment. For this reason, the service system has historically placed less emphasis on encouraging family involvement for adult consumers. In taking a person-centered approach to services, providers have to strike a balance between honoring consumers' preferences and encouraging the involvement of an individual's natural support network.

**Consumers with Developmental Disabilities (Table 2.2.b):** In three key areas related to service coordination and planning, almost all of North Carolina consumers surveyed in SFY 2006-07 reported they know their case manager, over three-fourths reported their case manager asks them about their preferences, and about four-fifths of consumers interviewed reported assistance in getting what they need (See Table 2.2.b). In all three measures of service coordination, North Carolina consumers responded much like consumers in other states using this survey.

<sup>13</sup> Only 4% of the families of adolescent MH consumers, 2% of families of child MH consumers, and 8% of the families of adolescent SA consumers reported having no involvement in either the planning or delivery of services.



SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2006-07, North Carolina (NC) compared to All Participating States (All).

The Division, LMEs and providers continue to incorporate person-centered thinking into all aspects of the service system. **The Division expects recent revisions to the standardized Person-Centered Planning form and continued trainings on its use to support gradual improvements in this area.**

### ***Domain 3: Promotion of Best Practices***

This domain refers to adopting and supporting those models of service that give individuals the best chance to live full lives in their chosen communities. It includes support of community-based programs and practice models that scientific research has shown to improve the behaviors and/or functioning of persons with disabilities. It also refers to promising practices that are recognized nationally. The Substance Abuse and Mental Health Services Administration (SAMHSA) requires states to report on the availability of evidence-based practices as part of the National Outcome Measures.

Supporting best practices requires adopting policies that encourage the use of natural supports, community resources and community-based service systems; funding the development of evidence-based practices; reimbursing providers who adopt those practices; and providing oversight and technical assistance to ensure the quality of those services.

#### **Measure 3.1: Persons Receiving Evidence-Based Practices**

##### **Consumers with Intellectual and Developmental Disabilities (I/DD):**

The Division has worked with its partners in the Department of Health and Human Services (DHHS) over the past year on several projects to increase the availability of best practice services to persons with developmental disabilities.

## **CAP-MR/DD Waiver**

The Division, in cooperation with the Division of Medical Assistance (DMA) manages DHHS' 1915(c) Home and Community-Based Waivers for persons with Developmental Disabilities. The Supports waiver and Comprehensive waiver were approved by the federal Centers for Medicare and Medicaid Services and implemented on November 1, 2008. Individual participants have been successfully transitioned to the two new waivers.

The Divisions are working to fully implement the two new waivers, including finalizing processes to implement two components of the Supports waiver – Self-Direction and the Request for Proposals for the Financial Management Agency. Other implementation tasks include the Risk Assessment process, the Supports Intensity Scale (SIS) assessment pilot project with seven LMEs, and the development of more refined data systems for quality management created by the new waivers.

The Division is planning two additional waivers to round out the four tiered waivers to enhance best practice approaches to delivering services and supports for individuals who experience Intellectual and Developmental Disabilities. The tiered waivers are being designed to address the specific needs of four different populations with differing service arrays. This will allow for more targeted service delivery and participant choice and responsibility.

## **MONEY FOLLOWS THE PERSON**

In May 2007, CMS awarded North Carolina a grant through Money Follows the Person (MFP) Rebalancing Demonstration Program established by the Deficit Reduction Act of 2005. The demonstration grant funding will end in September 2011. DHHS is using the funds to develop a roadmap for rebalancing the Medicaid long-term care delivery system. Staff from state agencies, providers, advocates and consumers have worked together to create this road map for operations – the Money Follows the Person Operational Protocol.

The goal is to provide a greater array of home and community-based services and supports designed to promote choice and independence for individuals who are aging with care needs, and/or have physical, mental, or developmental disabilities. The grant funding is intended to offer more transitional services for individuals wishing to move back into the community, to help individuals transitioning from public and private Intermediate Care Facilities for Mental Retardation (ICF/MRs), nursing facilities and/or institutions have access to assistive technology, and to increase the awareness and use of home and community based services through educational programs.

Specific protocols for working with the CAP waiver programs have been developed as a road map for staff in enrolling MFP-eligible recipients. To date, three individuals have been enrolled in the CAP/MR-DD waiver. Additionally, there are 29 individuals on the MFP referral list for CAP/MR-DD who are in the planning stages of transitioning. Of these, two are scheduled to transition to the community in March 2009.

## **NC-START**

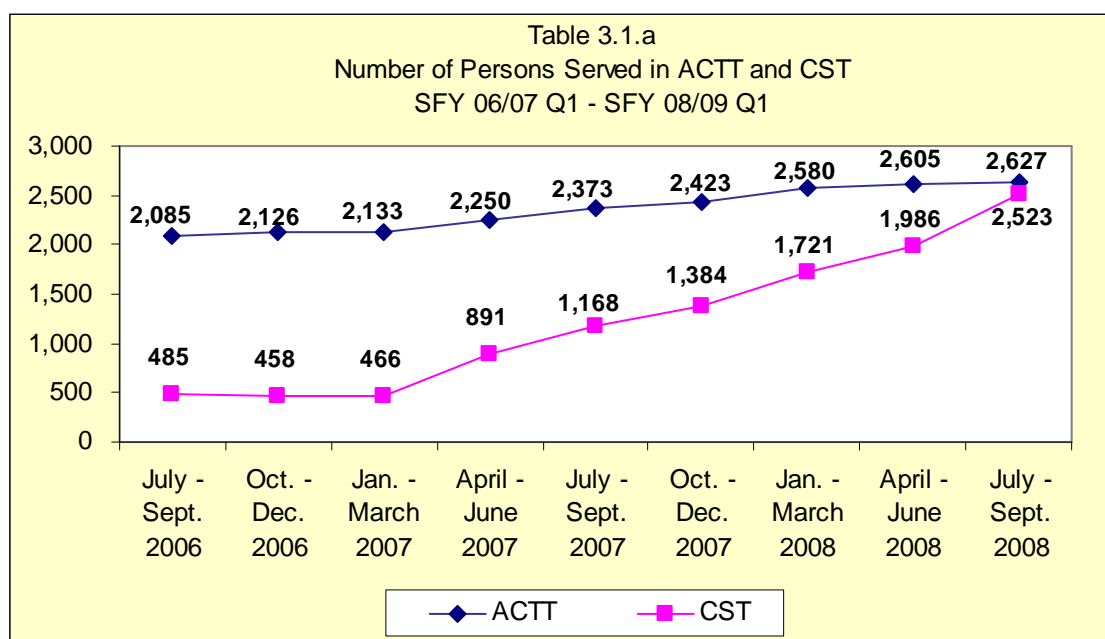
NC-START (Systemic, Therapeutic Assessment, Respite, and Treatment) provides enhanced crisis services and supports for individuals with I/DD and behavioral health needs. Although the model provides specialized services through a team of individuals, such as 24-hour crisis support, psychiatry and emergency respite, the main emphasis is on service linkages rather than a segregated service system. Individuals referred to NC-START move through the crisis services system just as other individuals in the MH/DD/SAS system, including access to first responder supports, and 24/7 crisis response services such



as Mobile Crisis. When it is determined that the needs of the individual exceed the expertise of the system, a referral to NC-START may be initiated.

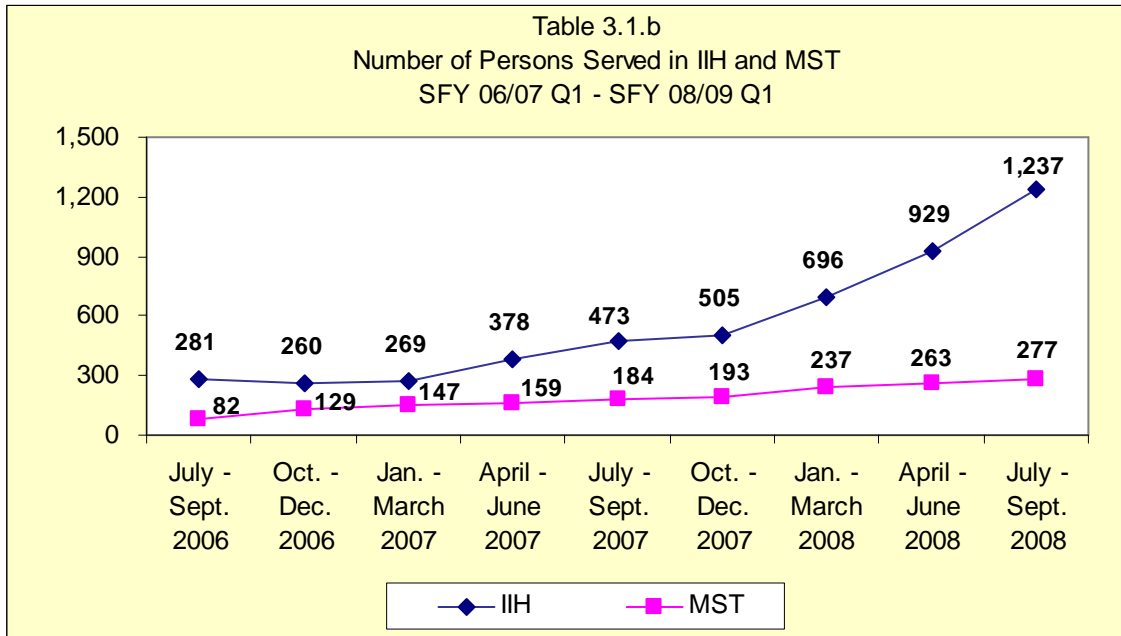
The primary focus of the teams is to prevent the use of emergency mental health and psychiatric inpatient services. There is an emphasis on prevention of crisis through identification of high risk individuals and on crisis planning and prevention. Key components of the model include (1) the provision of training and technical assistance to family members, providers, and community inpatient hospitals, (2) time limited, crisis respite, and (3) access to planned preventive respite to avert crisis. The Division is working collaboratively with the selected LMEs and providers to implement two clinical teams and a 4-bed crisis respite facility in each region of the state.

**Consumers with Mental Health Disabilities:** Adults with severe and persistent mental illnesses often need more than outpatient therapy or medications to maintain stable lives in their communities. Community support teams (CST) and assertive community treatment teams (ACTT) are designed to provide intensive, wrap-around services to prevent frequent hospitalizations for these individuals and help them successfully live in their communities. As shown in Table 3.1.a, the number of persons served in ACTT has been climbing steadily over the past two years (roughly increasing by 25 percent), while the number of persons served in CST has increased dramatically since the first quarter of SFY 2006-07.



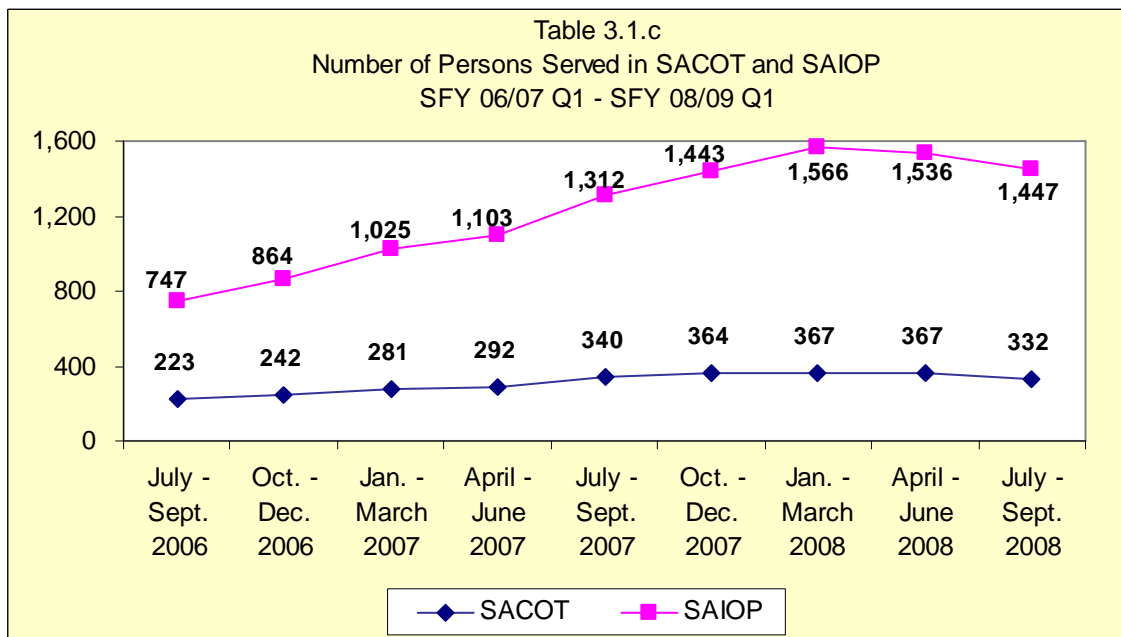
SOURCE: Medicaid and State Service Claims Data. July 1, 2006 - September 30, 2008.

Best practice services that support community living for children and adolescents with severe emotional disturbances and/or substance abuse problems require involvement of the whole family. Two of these best practices – intensive in-home (IIH) and multi-systemic therapy (MST) – help reduce the number of children who require residential and inpatient care. Table 3.1.b shows that the number of persons served in IIH has more than quadrupled since the first quarter of SFY 2006-07. During the same time period, the number of persons served in MST has increased almost three-fold.



SOURCE: Medicaid and State Service Claims Data. July 1, 2006 - September 30, 2008.

**Consumers with Substance Abuse Disabilities:** Recovery for individuals with substance abuse disorders requires service to begin immediately when an individual seeks care and to continue with sufficient intensity and duration to achieve and maintain abstinence. The substance abuse intensive outpatient program (SAIOP) and comprehensive outpatient treatment (SACOT) models support those intensive services using best practices, such as motivational interviewing techniques. Both SAIOP and SACOT have seen increases in the number of persons served during the last nine quarters, as seen in Table 3.1.c below. SACOT has increased the number of persons served by almost 50% since the first quarter of SFY 2006-07, while SAIOP has nearly doubled.



SOURCE: Medicaid and State Service Claims Data. July 1, 2006 - September 30, 2008.

The increase in persons receiving these best practice services has coincided with the decrease in inappropriate use of Community Support as a base service for many consumers. This rebalancing reflects a move to more person-centered decisions about appropriate service levels.

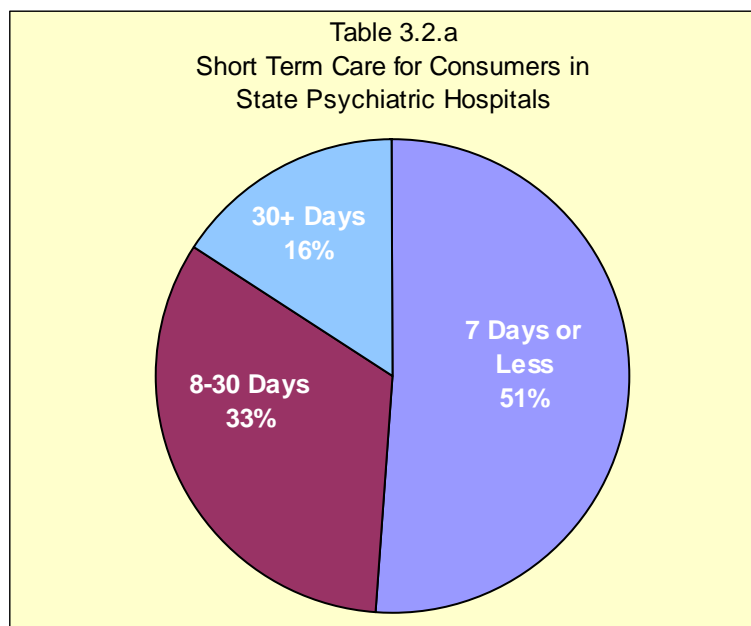
The Division expects to see continued rebalancing and stabilization of the service continuum to reflect the full array of service needs of consumers in the public system.

### Measure 3.2: Management of State Facility Usage

**Community Crisis Care and Short-Term Use of State Hospitals:** North Carolina is committed to developing a service system in which individuals are served in their home communities whenever possible. This is a particularly critical component of care in times of crisis. Service systems that concentrate on preventing crises and providing community-based crisis response services can help individuals to maintain contact with and receive support from family and friends, while reducing the use of state-operated psychiatric hospitals.

As has been reported previously, North Carolina has historically used its state psychiatric hospitals to provide more short-term care (30 days or less) than other states. The majority of states do not have short-term care units in their state hospitals. Instead acute care is provided in private hospitals, reserving the use of state psychiatric hospitals for consumers needing long-term care. As a result North Carolina has served more people overall in its state hospitals and average lengths of stay have been shorter than the national average.

Table 3.2.a shows that 84% of discharges during the first quarter of SFY 2008-09 (July through September 2008) were for consumers with lengths of stay for 30 days or less. Of the 2,459 discharges, 51% (n=1,256) were for consumers who discharged within 7 days of admission.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS)  
Data for discharges during July 1 - September 30, 2008; N=2,459 discharges.

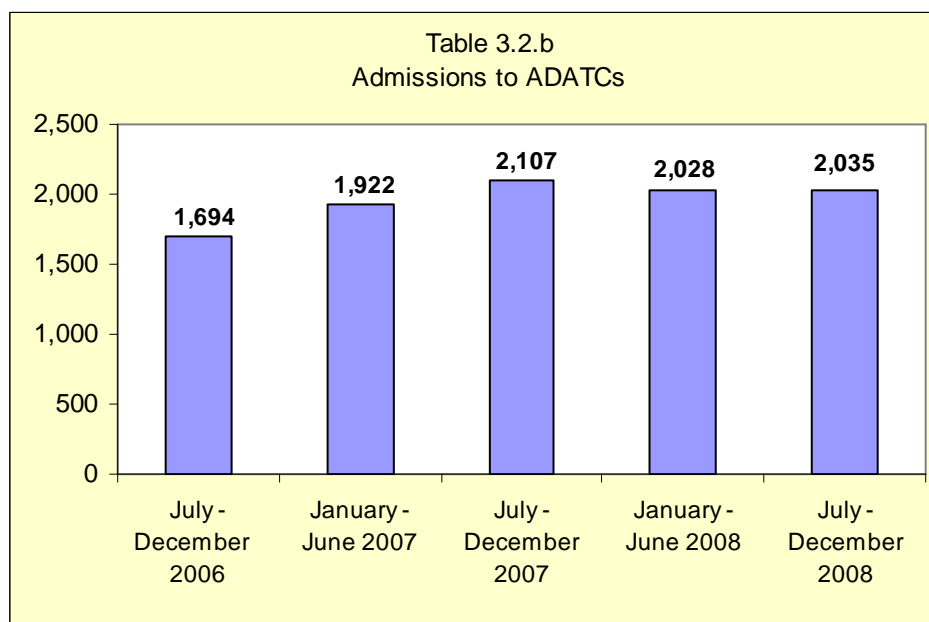
Development of a comprehensive community-based crisis services system and a focusing of state psychiatric hospital care on consumers with long-term needs is one of the five major objectives of *The State Strategic Plan: 2007-2010*.

The Division is currently using funds provided by the Legislature in 2008 to expand the start-up and operation of community crisis services to address this problem. These services represent best practices designed to maximize capacity to respond to consumer crises in ways that are minimally disruptive to their everyday lives, while reducing the use of state psychiatric hospitals for short-term crisis stabilization. These crisis services include:

- 30 Mobile Crisis Management Teams to provide integrated crisis response, crisis stabilization interventions, and crisis prevention activities, including immediate evaluation, triage and access to acute services and supports to reduce symptoms and potential for harm reduction. Of the 30 teams, 25 teams are currently in operation.
- 30 psychiatrists and related staff for walk-in crisis and immediate psychiatric aftercare. Telepsychiatric equipment will extend the reach of the psychiatrists by allowing provision of clinical care at a distance where on-site services are not available due to location, time of day, or availability of resources. These clinics will evaluate, triage, and assess individuals' needs, provide for immediate intervention, and refer individuals to appropriate ongoing care. They will also provide interim care, including medication management, to individuals discharged from a psychiatric or substance abuse facility pending appointment with their designated provider. The walk-in crisis and immediate psychiatric aftercare sites are in varying stages of preparation and operation.
- Six START teams and three 4-bed crisis respite facilities for persons with developmental disabilities (See Measure 3.1 for more information.) All teams and crisis respite beds are in operation.
- New local inpatient psychiatric beds/bed days to increase indigent acute care bed capacity across the state, which in turn diverts short-term admissions from state psychiatric hospitals. Community hospitals with these psychiatric inpatient beds will provide immediate short-term, intensive crisis care for individuals close to home and their family and friends, as outlined in three-way contracts between the community hospitals, LMEs and the Division. Currently eleven contracts have been signed and 75 new beds purchased. Other initiatives, not tied to the increased funding in 2008-2009, have also added another 70 new beds.

All of these crisis supports and programs play a critical role in the development of community infrastructure necessary to prevent psychiatric hospitalization and increase continuity of care for consumers between crisis services and appropriate ongoing services in the community.

**Acute Care in State Alcohol and Drug Treatment Centers:** In contrast to efforts to *reduce* the use of state psychiatric hospitals for acute care, the Division continues working to *increase* the use of state alcohol and drug treatment centers (ADATCs) for acute care. ADATCs are critical resources to serve individuals who are exhibiting primary substance abuse problems that are beyond the treatment capacity of local community services, but for whom psychiatric hospitalization is not appropriate. As shown in Table 3.2.b on the next page, admissions to all ADATCs increased by approximately 25% from the first two quarters of SFY 2006-07 to the first two quarter of SFY 2007-08. Since this time, admissions have leveled off to just over 2,000 admissions every six months. As of February 2009, JFK ADATC and WBJ ADATC are operating at full capacity. All construction is complete and the acute crisis units are open.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data for ADATC admissions during July 1, 2006 - December 31, 2008.

The Division expects the development of the full continuum of community crisis services and the opening of additional acute units in the ADATCs to reduce need for short-term admissions to the state psychiatric hospitals.

### **Measure 3.3: Continuity of Care Following Discharge from State Facilities**

Continuity of care for consumers after discharge from a state facility is critically important in preventing future crises and supporting an individual's successful transition to community living. A follow-up service within 7 days of discharge from a state facility is the current NC requirement in the *SFY 2009 DHHS-LME Performance Contract*.<sup>14</sup> Developmental centers adhere to a stricter best practice standard, which ensures that individuals moving to community settings receive extensive pre-discharge planning and immediate care upon discharge.

For individuals moving from the developmental centers to the community, transition planning begins many months prior to discharge.<sup>15</sup> This involves multiple person-centered planning meetings between the individual, their guardian, the treatment team and the provider that has been selected by the individual and their guardian. Service delivery begins immediately upon leaving the developmental center. Between January 1, 2008 and December 31, 2008, a total of 9 individuals were discharged from the general population of the developmental centers to the community.<sup>16</sup> All nine individuals went directly from

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<sup>14</sup> The Division adopted the Health Plan Employer Data and Information Set (HEDIS®) measure. However, best practice is for individuals with MH or SA disorders to receive care within 3 days. As the community service system stabilizes, the Division will increase expectations for timely follow-up community care.

<sup>15</sup> Best practice for persons with DD moving from one level of care to another is to receive immediate follow-up care that adheres to prior planning decisions that involved all relevant parties.

<sup>16</sup> This number does not include persons discharged from specialty programs or respite care in the developmental centers.

services at the developmental centers to services in the community. Table 3.3.a shows the type of community setting to which the individuals moved.<sup>17</sup>

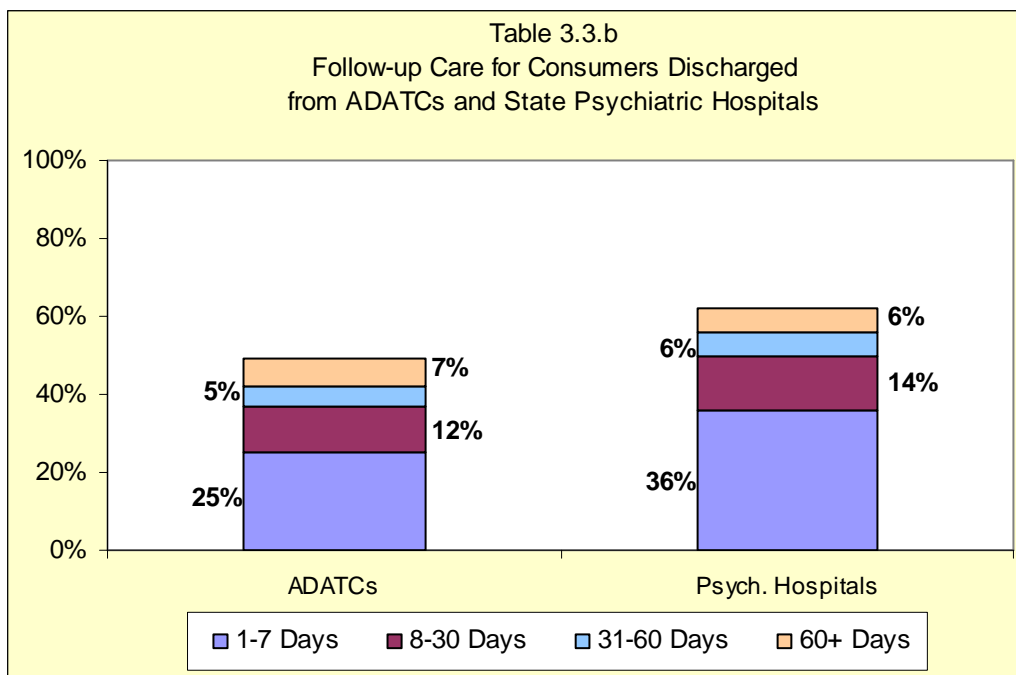
Table 3.3.a  
Follow-Up Care for DD Consumers Discharged from State Developmental Centers  
Calendar Year 2008

Time Period	Number of Individuals Moved to Community	Type of Community Setting
January – March 2008	2	1 to supervised living home 1 to alternative family living
April – June 2008	1	1 to ICF-MR group home
July – September 2008	2	2 to supervised living
October – December 2008	4	3 to ICF-MR group home 1 to supervised living home

As shown in Table 3.3.b, about half (49% out of 847) of the persons discharged from state ADATCs are seen for follow-up care, with one-fourth (25%) receiving care within 7 days of discharge. Follow-up care for the state psychiatric hospitals is somewhat better. Just over three-fifths (62% out of 2,639) of persons discharged from state psychiatric hospitals receive follow-up care, with 36% being seen within 7 days.

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<sup>17</sup> The data in Table 3.3.a includes the three Developmental Centers, and O’Berry Center. Effective July 2007, O’Berry Center designation changed to a neuro-medical treatment center.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Discharge Data (for HEARTS discharges April 1 - June 30, 2007); Medicaid and State Service Claims Data (for claims submitted April 1 - December 31, 2007)

The lack of timely follow-up after inpatient care has been an issue of concern for the Division. As a result, the Division has worked closely with LMEs to improve care coordination and follow-up services over the past several months. The Division expects the current emphasis on this critical continuity of care issue to improve the timeliness of follow-up care for persons discharged from state psychiatric facilities and ADATCs.

## ***Domain 4: Consumer-Friendly Outcomes***

Consumer Outcomes refers to the impact of services on the lives of individuals who receive care. One of the primary goals of system reform is building a recovery-oriented service system. Recovery for persons with disabilities means having independence, stability and control over one's own life, being considered a valuable member of one's community and being able to accomplish personal and social goals.

All people – including those with disabilities – want to be safe, to engage in meaningful daily activities, to enjoy time with supportive friends and family and to participate positively in the larger community. The SAMHSA National Outcome Measures and the CMS Quality Framework include measures of consumers' perceptions of service outcomes and measures of functioning in a variety of areas, including:

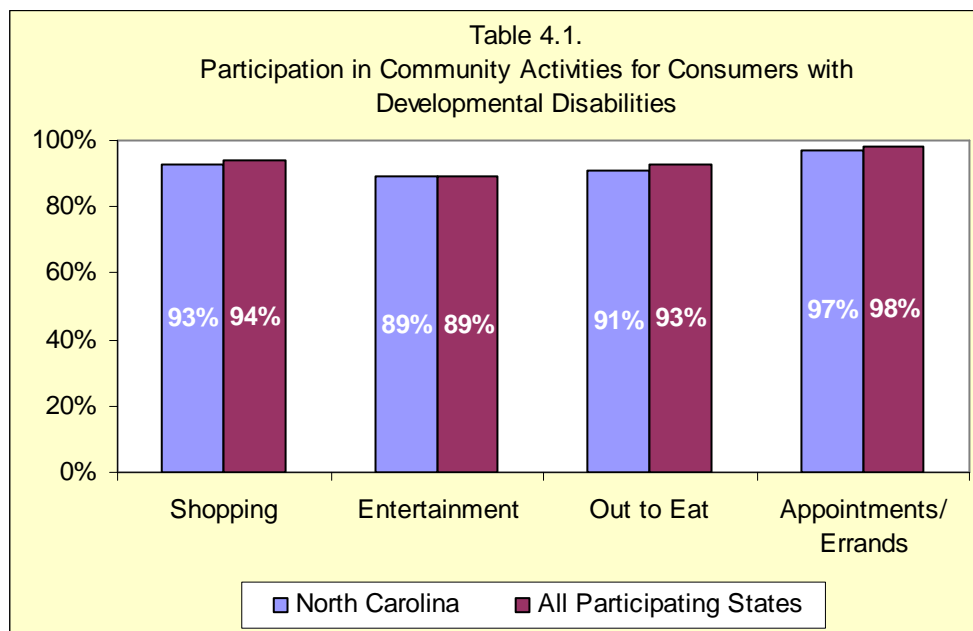
- Symptom reduction, abstinence, and/or behavioral improvements.
- Housing stability and independence.
- Employment and education.
- Social connectedness.
- Reduction in criminal involvement.

The Division is currently working to ensure that individual progress on these consumer outcomes is addressed as a regular part of developing person-centered plans for every consumer. Based on analysis of

current information, the Division has identified improvements in housing and employment opportunities as strategic objectives for the next three years. Division and local agencies will continue analyzing consumer outcomes data to monitor progress in these areas and to identify other areas that require policy development or targeting of funds for training and technical assistance in clinical practice and for other service system enhancements.

#### Measure 4.1: Outcomes for Persons with Developmental Disabilities

In annual interviews with consumers with developmental disabilities in SFY 2006-07, the overwhelming majority of North Carolina consumers reported participation in community life (see Table 4.1 below). In all four areas of community participation (shopping, entertainment, going out to eat, and running errands) North Carolina consumers did not differ from consumers among all states using the survey. (See Appendix D for details on this survey.)



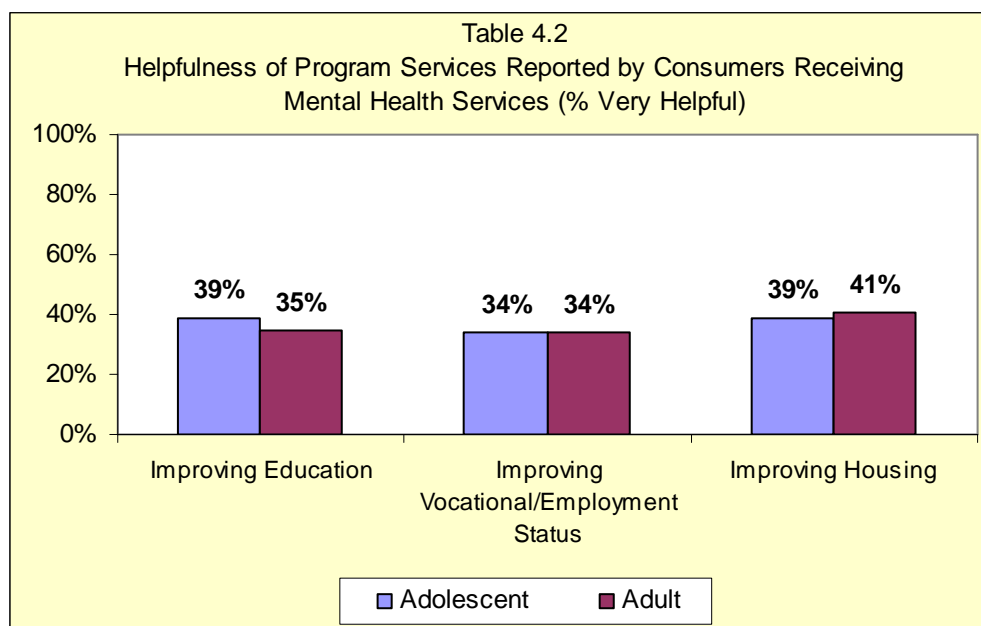
SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2006-07, North Carolina (NC) compared to All Participating States (All).

#### Measure 4.2: Outcomes for Persons with Mental Health Disorders

For persons with mental illness, housing and employment are important to regaining personal control of one's life. Successful engagement in services for even three months can begin to build the stability and control that improve consumers' lives and give them hope for further recovery.

Table 4.2 shows how mental health consumers in SFY 2007-08 perceived the impact of the first three months of treatment in three key areas of their lives. While three months is insufficient time to judge the long-term effect of treatment, building hope at the outset is an important factor in engaging individuals in their treatment and sustaining improvements over time (See Appendix D for details on the NC-TOPPS system used to collect this data.)





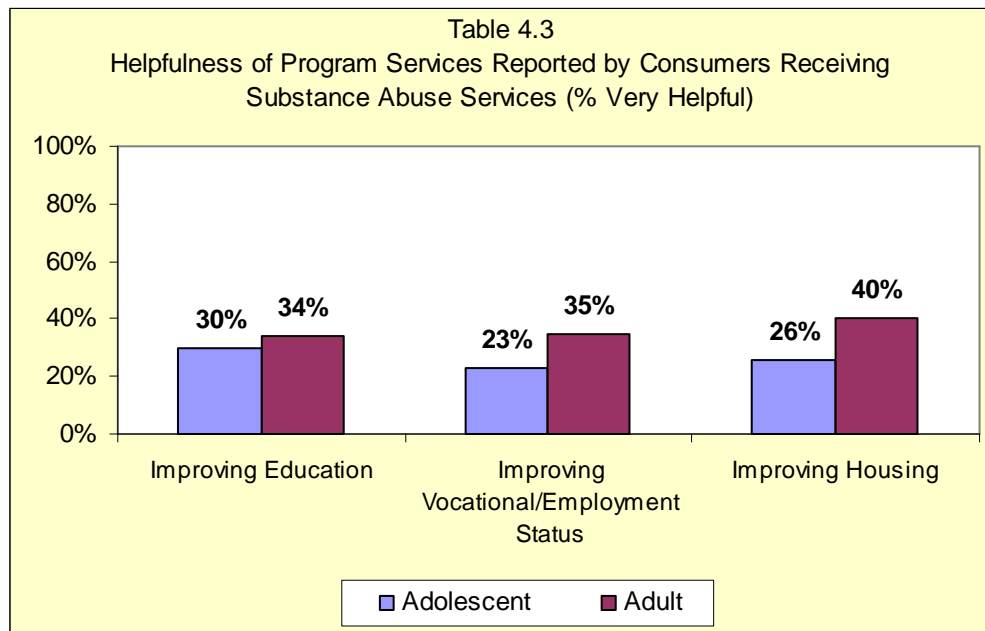
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS)  
Data. 3 Month Update Interviews conducted July 1, 2007 - June 30, 2008

- Slightly more adolescents (39%) than adults (35%) reported that services helped improve their education.
- Slightly more than one-third of adolescents and adults reported improvements in their vocational/employment status.
- Approximately two-fifths of adolescents and adults reported improvements in housing.

### Measure 4.3: Outcomes for Persons with Substance Abuse Disorders

Individuals with substance abuse disorders, like those with mental illness, need stable housing and employment to regain personal control of their lives. Successful engagement in the first three months of service is especially critical for this population of consumers, because of the chronic, debilitating nature of addictions.

Table 4.3 shows how substance abuse consumers in SFY 2007-08 perceived the impact of the first three months of treatment in three key areas of their lives. Again, perceptions after three months of service is primarily an indicator of the individual's hope for recovery and engagement in services, both of which are key for achieving and sustaining improvements over time. (See Appendix D for details on the NC-TOPPS system used to collect this data.)



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS)  
Data. 3 Month Update Interviews conducted July 1, 2007 - June 30, 2008

Overall, SA consumers' perceptions of care are much like those of MH consumers.

- Less than one third of adolescent SA consumers and slightly more than one-third of adult SA consumers reported that services helped improve their education.
- More adults (35%) than adolescents (23%) reported improvements in their vocational/employment status.
- Two-fifth of adult SA consumers reported improvements in housing compared to just a quarter of adolescents (26%).

In terms of employment initiatives, the Division is identifying partners and new opportunities at the state and local levels for braided funding whereby resources are combined from various employment service entities to provide employment services for individuals with mental illness or developmental disabilities.

The Division's housing specialist is collaborating with the DHHS' Office of Housing and Homelessness and the North Carolina Housing Finance Agency (NC HFA) to expand community housing opportunities for extremely low-income households. In particular, they are working together on representing the needs, identifying gaps, and promoting the expansion of community housing opportunities with an emphasis toward linking consumers with accessible community based supportive services. Specific housing activities/initiatives include the following:

**The Key Program.** This program makes housing affordable by paying the difference between what a tenant on SSI income can afford to pay toward their housing costs, and the cost of operating the unit. In 2006, 2007, and 2008, the legislative budgets totaling \$6.7 million of recurring funds for the Key Program has expanded the key operating subsidies making a total of 681 rental units affordable to persons living on disability income which includes MH/DD/SAS consumers.

**The Housing Credit Targeting Program.** In 2008 the North Carolina General Assembly continued its support for permanent affordable supportive housing by appropriating \$7.5 million in nonrecurring funds

to the Housing Trust Fund for the development of additional independent apartments. Currently statewide there are 1,780 funded targeted units for persons with disabilities that are in various stages of development.

***Local Housing Specialists.*** Housing Specialists perform a critical function as the local lead agency to ensure that MH/DD/SAS consumers have access to affordable housing and supportive services which is exemplified in the Targeting Program's achievement by executing a 93 percent occupancy rate in July 2008. The Division has funded at least one housing specialist position in all 24 LMEs, with a total of 28 positions across the state. The housing specialists work with community service providers, public housing agencies and private landlords to increase housing opportunities for consumers. The housing specialists also work with the low-income housing tax credit targeted units as the referral agents and the contact for the development management over the life of the project. It is vital that they assure that the targeted units are utilized and that the tenants have access to the supportive services that they may need to live successfully in the community.

***North Carolina Oxford Houses (NC OH) Housing Support Initiatives.*** Through \$200,000 in annual recurring State appropriations and \$50,000 in federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds, the Division contracts with Oxford House, Inc. to provide services to consumers recovering from substance use disorders in a low-cost, peer supportive living environment. NC OH staff provides support services, including 24-hour on call services to these consumers. As of December 31, 2008, Oxford House of North Carolina had a total of 129 Oxford Houses in 31 cities with 728 beds for men and 235 beds for women. The success of these houses were made possible by North Carolina starting a Revolving Loan program with \$140,000 that has provided 181 loans to Oxford Houses, which in turn has generated \$624,725 in start-up loans for Oxford Houses since 1991. In addition, NC OH has a Criminal Justice Pilot Initiative that has the goal of offering clean, safe, and affordable drug free housing for substance abusing inmates leaving incarceration.

***The Housing Needs Study.*** In response to the S.L. 2007-032 Section 10.49 (h2) requirement for the DHHS and the NC HFA to produce a report to the Legislative Oversight Committee that addresses disability specific housing needs, the Division has contracted with a national non-profit organization that works to achieve positive outcomes on behalf of people with disabilities, people who are homeless, and people with other special needs. The information obtained from this study will guide the Division in identifying North Carolina's housing needs and current resources, to identify best practice housing and service models, as well as to provide the Division with recommendations and a plan for implementation, additions and/or changes to North Carolina's residential service array that will maximize available Federal and State resources.

***Projects for Assistance in Transition from Homelessness (PATH).*** This program is a Federal grant program administered by the state to fund assertive outreach, engagement and time-limited case management services to individuals who are not receiving any mental health services and are homeless and have serious mental illness. (PATH can also service veterans or people with co-occurring disorders). This program has been in operation in North Carolina for the past 15 years, and models nationally identified best practices on engaging the homeless. In SFY 2007-08, \$932,000 in PATH funds were received by ten LMEs with the largest homeless populations in the state. With these funds, 4,646 homeless adults received outreach services and 871 individuals received PATH services.

The Division expects these efforts to improve the housing and employment situations of consumers, once the current statewide economic situation has improved.

## **Domain 5: Quality Management Systems**

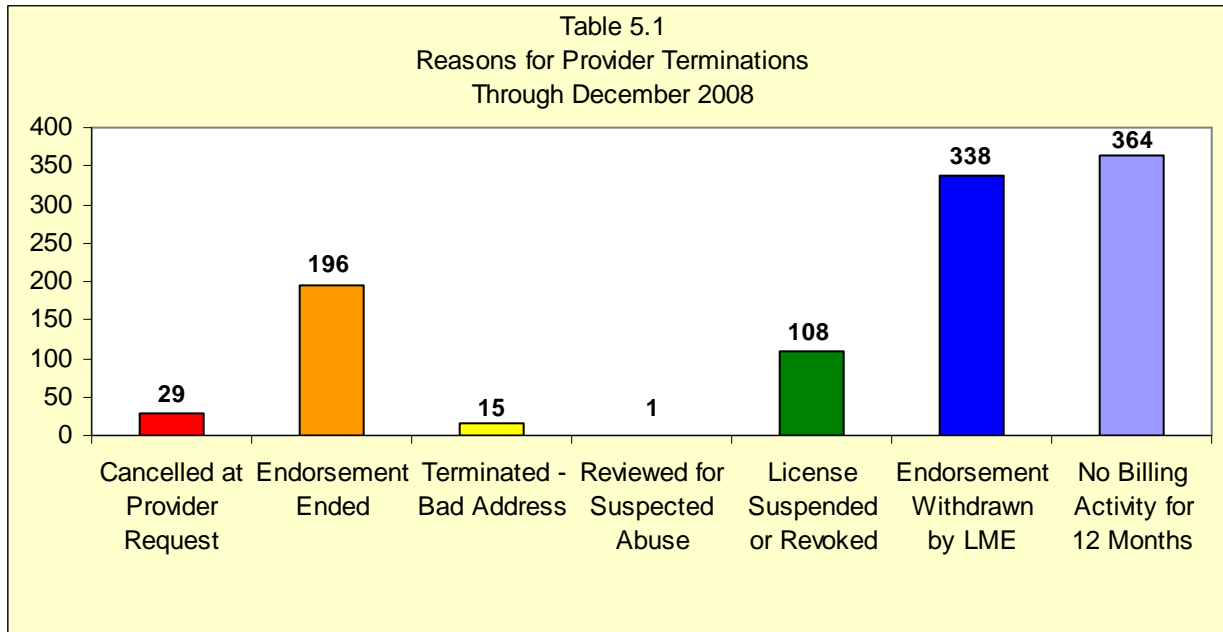
Quality Management refers to a way of thinking and a system of activities that promote the identification and adoption of effective services and management practices. The Division has embraced the CMS Quality Framework for Home and Community-Based Services, which includes four processes that support development of a high-quality service system:

- **Design**, or building into the system the resources and mechanisms to support quality.
- **Discovery**, or adopting technological and other systems to gather information on system performance and effectiveness.
- **Remediation**, or developing procedures to ensure prompt correction of problems and prevention of their recurrence.
- **Improvement**, or analyzing trends over time and patterns across groups to identify practices that can be changed to become more effective or successful.

These processes include activities to ensure a foundation of basic quality and to implement ongoing improvements. The first set of activities, often labeled **quality assurance**, focuses on compliance with rules, regulations and performance standards that protect the health, safety and rights of the individuals served by the public mental health, developmental disabilities and substance abuse services system. The second set of activities, labeled **quality improvement**, focuses on analyzing performance information and putting processes in place to make incremental refinements to the system.

### **Measure 5.1: Assurance of Basic Service Quality**

In the past two years the Division has worked with its partners at the Division of Medical Assistance (DMA) and LMEs to gain control over the explosion of community support providers that ensued after implementation of the new service definitions in March 2006. After completing clinical reviews of services in October 2007, Medicaid enrollment of community support providers was halted. The number of providers decreased by 14% in 2008 as a result of this and other actions to curb inappropriate use of this important service (1,498 active providers in January 2008 has dropped to 1,291 active providers in December 2008). As of the end of the calendar year, 574 providers have had their Medicaid enrollment terminated voluntarily or involuntarily. As shown in Table 5.1, while more than one reason could be cited, the two most frequent reasons for termination were a lack of billing activity for twelve months (n=364) and having endorsement withdrawn by an LME (n=338).



SOURCE: Information taken from the *Monthly Report to the General Assembly on Community Support Services*, December 2008, published January 31, 2009.

While community support services have been contained at a more appropriate level, the Division has begun to see a growth in providers of other needed services. This trend toward a more balanced continuum of service providers will help to ensure that consumers can find an appropriate level of service as well as a choice among providers. (See Measure 3.1 for more information on services.)

Since the clinical reviews of community support services were completed, the Division has implemented standard tools for assessing provider risk and evaluating provider quality. These tools were developed through collaboration among Division, LME and provider staff. After piloting in the fall of 2008, LMEs have begun using the tools in 2009 to monitor their community providers on a regular basis.

The Division expects this statewide monitoring process to improve provider quality across the service continuum in the coming year.

### Measure 5.2: Quality Improvement Activities

Over the past year, the Division has worked with LMEs, providers and consumers to make a number of improvements to its consumer outcomes system, North Carolina Treatment and Outcome Program Performance System (NC-TOPPS).

- **Shorter Online Consumer Interviews.** At the behest of stakeholders, the online mental health and substance abuse interviews were shortened by a third and reorganized to make them easier to navigate.
- **Improved User Enrollment Process.** The time required to enroll new clinicians in the system was streamlined and the process for addressing clinicians' requests for changes to their enrollment was improved.
- **Consumer Progress Reports.** The NC-TOPPS team will soon be providing clinicians with the capability to produce a one-page individual consumer report that compares 17 key outcome measures

from a consumer's start of treatment to specific points during treatment. It can be used by the clinician to help a consumer see how she/he is doing over time.

- **Outcomes at a Glance Dashboard.** This online report system allows the public to view and print graphs showing current statewide and LME-specific information on meaningful outcomes for substance abuse and mental health consumers. The data for these important measures, which include National Outcomes Measures such as Alcohol and Drug Use, Employment, Homelessness and Mental Health Symptoms, are updated monthly. The "Outcomes at a Glance" dashboard can be found at the NC-TOPPS page of the Division's website at <http://www.ncdhhs.gov/mhddsas/nc-toppas/>.

**SOMMS-Dashboard - Mozilla Firefox**

File Edit View Go Bookmarks Tools Help

http://nc-toppas.ncdmh.net/dashboard/

DMH Public Site DHHS Web DMH Staff Directory NC Mail Webmail DMH Intranet NC Homepage Substance Abuse and... 5 Day Forecast :: WR... Cathedral School Yahoo! Peak

NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services

**NC-TOPPS**

**OUTCOMES AT A GLANCE**

Quality NC DMH/DD/SAS

1. CHOOSE OUTCOME MEASURE:  
--Select--

2. CHOOSE POPULATION:  
☒ State ☐ LME

3. CHOOSE UP TO 5 LMEs:  
A-C-R  
Albemarle  
Beacon Ctr  
CenterPoint  
Crossroads  
Cumberland  
Piedmont  
add remove

4. CHOOSE CONSUMER GROUP:  
Adult Mental Health  
Adult Substance Abuse  
Adolescent Mental Health  
Adolescent Substance Abuse  
Child Mental Health

5. CHOOSE CHART TYPE:  
☒ Column ☐ Bar  
☐ Show as 3D  
☒ Show Value

SUBMIT RESET

Welcome to the NC DMH/DD/SAS outcomes dashboard.

By choosing from the options at the left, you can view and print graphs showing current information about **substance abuse and mental health consumer outcome measures**. To determine outcomes, information received during an interview when the consumer is admitted to treatment is compared to another interview during treatment. Local Management Entities (LMEs) are responsible for sending this information to NC-TOPPS, the Division's Treatment Outcomes & Program Performance System.

The data presented here are based on consumers' completed update interviews in the most recent six months. For example, when you look at data in June 2008, you will see data from update interviews completed from December 1, 2007 through May 31, 2008.

To protect consumer privacy, this is aggregate data only that must include more than 20 people.

Done

start SOMMS-Dashboard - ... 8:47 AM

Making current data readily and easily accessible is essential to good system coordination, management and improvement at both state and local levels. The Division expects to continue enhancing its data system integration and improving its usefulness for knowledge management and quality improvement as budget considerations allow.

## Domain 6: System Efficiency and Effectiveness

System efficiency and effectiveness refers to the capacity of the service system to use limited funds wisely -- to serve the persons most in need in a way that ensures their safety and dignity while helping

them to achieve recovery and independence. An effective service system is built on an efficient management system, key features of which include good planning, sound fiscal management and diligent information management.

The annual *DHHS-LME Performance Contract* serves as the Division's vehicle for evaluating LME efficiency and effectiveness. It lays out the requirements for each function that the LME is contracted to fulfill. In addition, the contract contains statewide measures with annual performance standards and projected targets that the Division tracks and reports on its website in the quarterly *Community Systems Progress Reports*. For SFY 2009 the Division has also begun providing this information in a one-page matrix format, called "*Critical Measures at a Glance*." The LMEs are expected to develop and implement strategies for improving areas of weakness and achieving the Division's statewide targets.

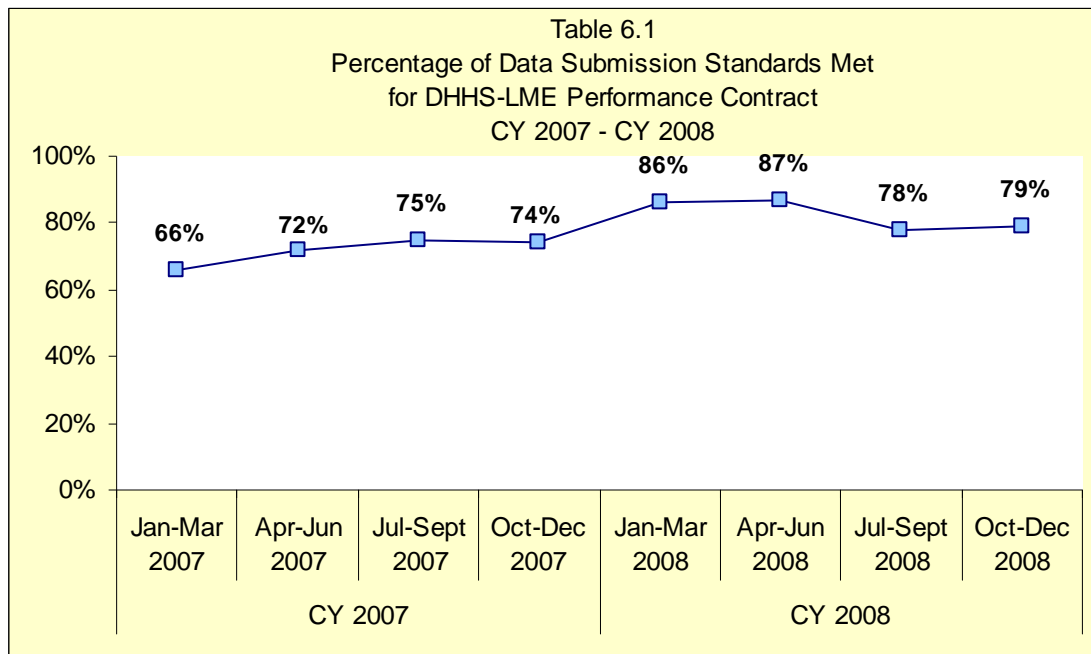
### **Measure 6.1: Business and Information Management**

Making good decisions requires the ability to get accurate, useful information quickly, easily and regularly. It also requires efficient management of scarce resources. Staff at all levels need to know the status of their programs and resources in time to take advantage of opportunities, avoid potential problems, make needed refinements and plan ahead.

Consumer data, along with service claims data reported through the Integrated Payment and Reimbursement System, the Medicaid claims system, and the Healthcare Enterprise Accounts Receivable Tracking System, provide the information that the LMEs and the Division use to evaluate local and state system performance and to keep the Legislature informed of system progress.

For these reasons, compliance is critical to LME and Division efforts to manage the service system. The *DHHS-LME Performance Contract* includes requirements for timely and accurate submission of financial and consumer information. Taken together, the LMEs' compliance with reporting requirements provides an indication of the system's capacity for using information to manage the service system efficiently and effectively.

As shown in Table 6.1, local management entities' submission of timely and accurate information to the Division has risen and fallen since the beginning of CY 2007 but has overall seen an increase from two-thirds of submission standards met to four-fifths of the standards met. Submission of data climbed to 87% by the middle of CY 2008 but fell to 79% by the end of the calendar year.



SOURCE: Data from Quarterly Performance Contract reports.

Since much of the LMEs' data on consumers now comes from private providers, additional training and good ongoing communication between LMEs and providers is necessary to ensure the timely flow of information. The Division provides ongoing monitoring and technical assistance to LMEs to help ensure the timely and accurate flow of information. The LMEs, in turn, use provider compliance with data reporting requirements, as a factor in determining their provider monitoring decisions.

The key to efficient management and use of information, however, lies in integrating data into a seamless coherent system that provides a complete picture of an individual consumer's situation, a community's resources, or a state system's challenges. The Division is currently implementing an electronic health record system at Central Regional Hospital that will begin to provide that coherence. That system will be rolled out to other state facilities. At the same time, the Division is compiling the requirements for a statewide community-based electronic health record and management information system that will be able to interface with the facilities' electronic health record system. Only when those projects are completed will system managers have the most cost-effective tools available for managing the service system.

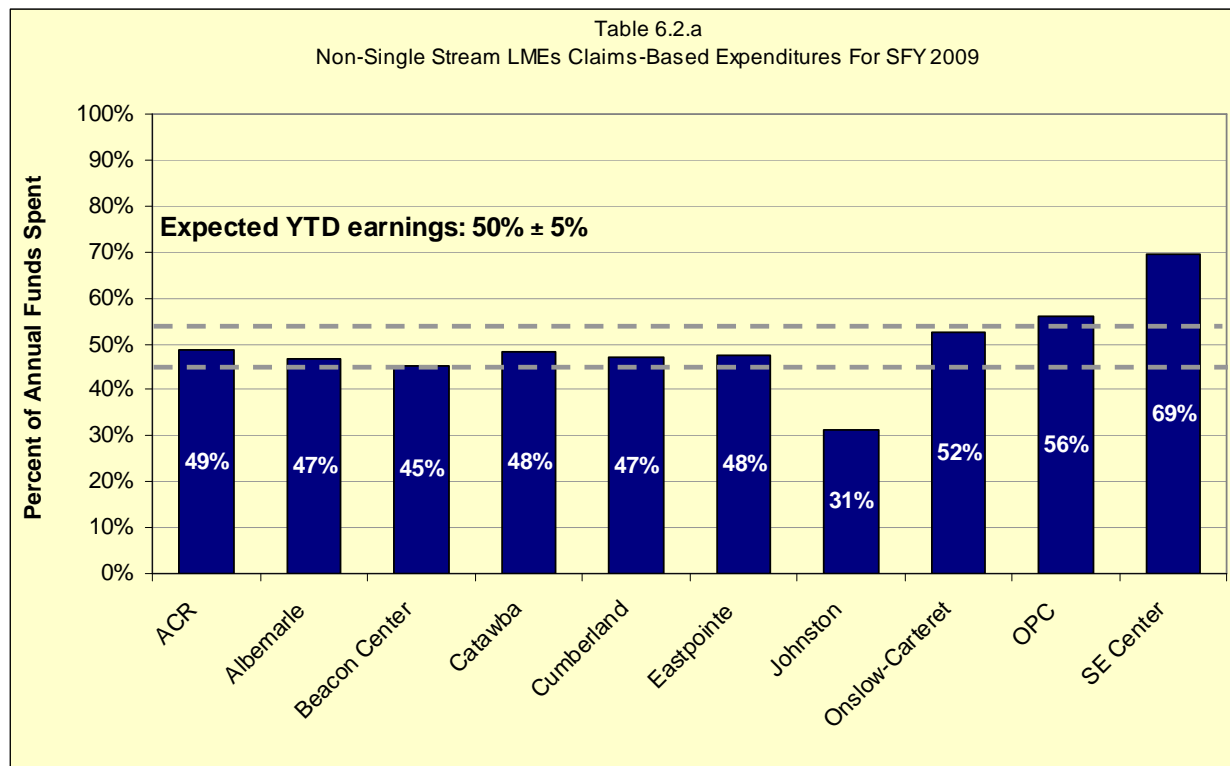
The Division expects to continue enhancing its data system integration and improving its usefulness for knowledge management and quality improvement as budget considerations allow.

### Measure 6.2: Efficient Management of Service Funds

As stated above, service claims data reported through the Integrated Payment and Reimbursement System (IPRS) have been a major source of information for the Division to evaluate local and state system performance and to keep the Legislature informed of system progress through this report. Providing effective services requires careful management of limited fund allocations over the course of the fiscal year to ensure that funds are continuously available to serve those most in need, without being left unspent at the end of the fiscal year. Overspending of funds early in the year leaves no reserves for those who enter the system or continue to need services later in the year. Underspending of funds means that some who could have been served were not.

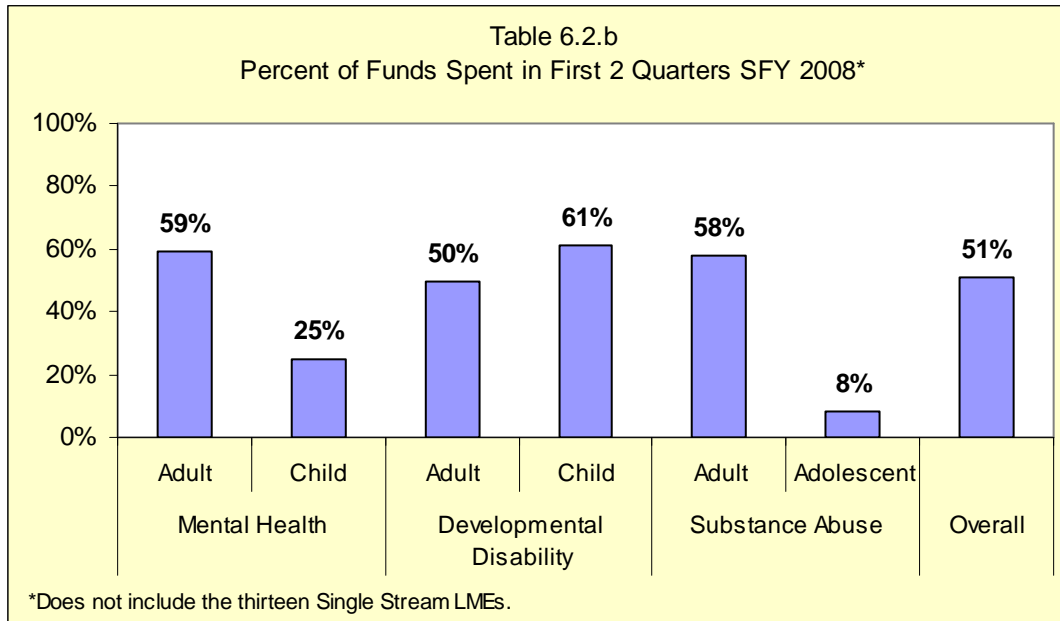


Table 6.2.a shows the expenditures of state funds by LMEs earning funds through traditional claims submission to IPRS during the first two quarters of SFY 2009.<sup>18</sup> Across all disabilities, traditional LMEs spent from 31% to 69% of their LME-managed service funds during the first and second quarters of SFY 2009, with an average for these nine LMEs of approximately half of their funds spent by the end of the second quarter of SFY 2009, as expected (see Table 6.2.b). As shown in Table 6.2.b, of all the disability groups, the expenditures for adolescent substance abuse consumers lagged behind the others. In fact, only 8% of the allocations for adolescent substance abuse services were expended in the first two quarters of SFY 2009. Expenditures for child mental health consumers were not too far behind adolescent substance abuse consumers with only 25% of the allocations expended in the first two quarters.



SOURCE: Integrated Payment and Reporting System Service Data (for claims submitted July 1 - December 31, 2008)

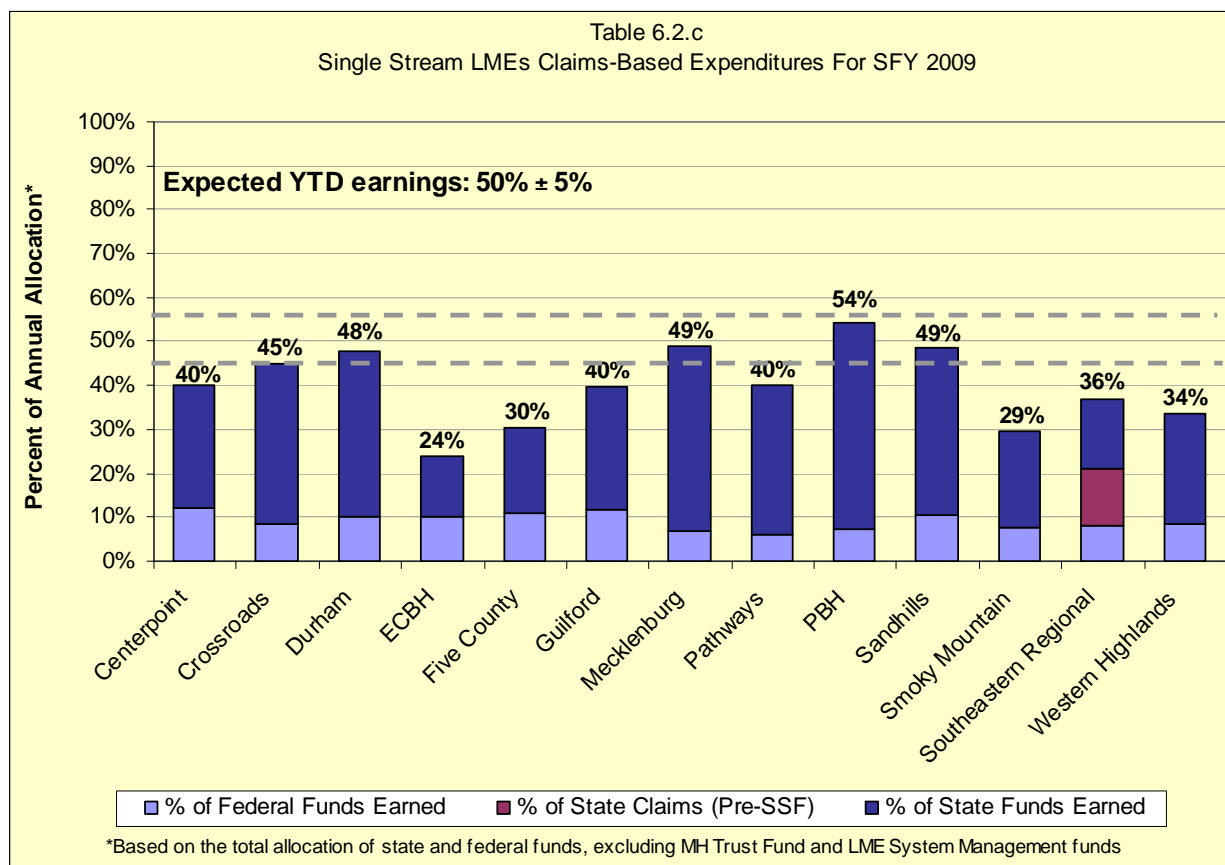
<sup>18</sup> Ideally 50% of funds would be spent by the end of the second quarter of the state fiscal year.



SOURCE: Integrated Payment and Reporting System Service Data (for claims submitted July 1 - December 31, 2008)

The Division has simplified the target populations and rules for drawing down funds through IPRS, as a way to provide LMEs with more flexibility in spending their state dollars. In addition, the Division has implemented LME-specific alternative services in SFY 2009 to encourage LMEs to find innovative ways to develop needed services for underserved groups. The Division expects these changes to the reimbursement system to increase service availability for underserved populations.

Single stream funding is another mechanism that provides LMEs with flexibility in use of their funds. As indicated in Table 6.2.c below, only five of the LMEs (Crossroads, Durham, Mecklenburg, PBH, and Sandhills) receiving single-stream funding in the first six months of SFY 2009 have reported the expected expenditures as “shadow claims” for this same time period. Three LMEs (CenterPoint, Guilford, and Pathways) are not too far behind in their reporting of services. The remaining five LMEs (ECBH, Five County, Smoky Mountain, Southeastern Regional, and Western Highlands) are reporting less than forty percent of their allocation spent in the first half of the state fiscal year.



SOURCE: Integrated Payment and Reporting System Service Data (for shadow claims submitted by Single-Stream Funded LMEs, July 1 - December 31, 2008)

The Division has developed criteria to determine an LME's eligibility to continue receiving single stream funding from one fiscal year to the next. These criteria include, among other requirements, submission of shadow claims for at least 85% of state funds to ensure that the Division continues to have the data needed for evaluating the performance of the service system.

## Domain 7: Prevention and Early Intervention

Prevention and Early Intervention refers to activities designed to minimize the occurrence of mental illness, developmental disabilities, and substance abuse whenever possible and to minimize the severity, duration, and negative impact on persons' lives when a disability cannot be prevented. **Prevention** activities include efforts to educate the general public and specific groups known to be at risk. Prevention education focuses on the nature of MH/DD/SA problems and how to prevent, recognize and address them appropriately. **Early intervention** activities target individuals who are experiencing early signs of an emerging condition to halt its progression or significantly reduce the severity and duration of its impact.

Preventing or intervening early in a potential problem is much more effective – both clinically and financially – than treating a disability that has already caused major impairments and negative consequences in an individual's and family's life. Increasing national attention is being given to preventing or minimizing the impact of mental illness and developmental disabilities in consumers' lives. SAMHSA's National Outcome Measures (NOMS) emphasize the use of evidence-based programs to educate at all levels and intervene with individuals who may be experiencing early problems associated with substance use.

## **Measure 7.1: North Carolina Prevention Outcomes Performance System**

In October 2008 the Division rolled out the *North Carolina Prevention Outcomes Performance System (NC POPS)*, a statewide system for collecting information on the activities of substance abuse prevention programs. The Division contracted with a national vendor to provide the system free of cost to all LMEs and prevention providers. NC POPS will eventually be the one-stop online system for documenting, monitoring and evaluating all prevention related activities in the State of North Carolina. The paper-based reports will be phased out by the middle of SFY 2009-10 at which time all reporting will become automated.

All provider agencies contracted by LMEs to provide prevention services are expected to use NC POPS to do annual planning and to document the programs and services they provide. LMEs are responsible for reviewing and monitoring information submitted by the provider agencies into the system for accuracy and consistency with previous reporting periods.

NC POPS is designed on the five-step Strategic Prevention Framework of assessment, capacity building, planning, implementation, and evaluation that is supported by the federal Center for Substance Abuse Prevention. As such, it encourages providers to adopt the accepted process for delivering prevention services and captures the National Outcomes Measures for prevention.

The Division expects the NC-POPS to improve its capacity to manage and improve the reach and effectiveness of prevention activities across the state.

## **Appendix A: Legislative Background**

Session Law 2006-142 Section 2.(a)(c) revised the NC General Statute (G.S.) 122C-102(a) to read:

“The Department shall develop and implement a State Plan for Mental Health, Developmental Disabilities and Substance Abuse Services. The purpose of the State Plan is to provide a strategic template regarding how State and local resources shall be organized and used to provide services. The State Plan shall be issued every three years beginning July 1, 2007. It shall identify specific goals to be achieved by the Department, area authorities, and area programs over a three-year period of time and benchmarks for determining whether progress is being made toward those goals. It shall also identify data that will be used to measure progress toward the specified goals....”

In addition, NC G.S. 122C-102(c) was revised to read:

“The State Plan shall also include a mechanism for measuring the State’s progress towards increased performance on the following matters: access to services, consumer friendly outcomes, individualized planning and supports, promotion of best practices, quality management systems, system efficiency and effectiveness, and prevention and early intervention. Beginning October 1, 2006, and every six months thereafter, the Secretary shall report to the General Assembly and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services, on the State’s progress in these performance areas.”

## Appendix B: SAMHSA National Outcome Measures

Substance Abuse and Mental Health Services Administration  
National Outcome Measures (NOMs)

DOMAIN	OUTCOME	MEASURES		
		Mental Health	Substance Abuse	
			Treatment	Prevention
Reduced Morbidity	Abstinence from Drug/Alcohol Use	NOT APPLICABLE	Reduction in/no change in frequency of use at date of last service compared to date of first service ►	30-day substance use (non-use/reduction in use) ► Perceived risk/harm of use ► Age of first use ► Perception of disapproval/attitude
	Decreased Mental Illness Symptomatology	Under Development	NOT APPLICABLE	NOT APPLICABLE
Employment/Education	Increased/Retained Employment or Return to/Stay in School	Profile of adult clients by employment status and of children by increased school attendance ►	Increase in/no change in number of employed or in school at date of last service compared to first service ►	Perception of workplace policy; ATOD-related suspensions and expulsions; attendance and enrollment
Crime and Criminal Justice	Decreased Criminal Justice Involvement	Profile of client involvement in criminal and juvenile justice systems	Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service ►	Alcohol-related car crashes and injuries; alcohol and drug-related crime
Stability in Housing	Increased Stability in Housing	Profile of client's change in living situation (including homeless status) ►	Increase in/no change in number of clients in stable housing situation from date of first service to date of last service ►	NOT APPLICABLE
Social Connectedness	Increased Social Supports/Social Connectedness <sup>1</sup>	Under Development	Under Development	Family communication around drug use
Access/Capacity	Increased Access to Services (Service Capacity)	Number of persons served by age, gender, race and ethnicity ►	Unduplicated count of persons served; penetration rate-numbers served compared to those in need ►	Number of persons served by age, gender, race and ethnicity
Retention	Increased Retention in Treatment - Substance Abuse	NOT APPLICABLE	Length of stay from date of first service to date of last service ► Unduplicated count of persons served ►	Total number of evidence-based programs and strategies; percentage youth seeing, reading, watching, or listening to a prevention message
	Reduced Utilization of Psychiatric Inpatient Beds - Mental Health	Decreased rate of readmission to State psychiatric hospitals within 30 days and 180 days ►	NOT APPLICABLE	NOT APPLICABLE
Perception of Care	Client Perception of Care <sup>2</sup>	Clients reporting positively about outcomes ►	Under Development	NOT APPLICABLE
Cost Effectiveness	Cost Effectiveness (Average Cost) <sup>2</sup>	Number of persons receiving evidence-based services/number of evidence-based practices provided by the State	Number of States providing substance abuse treatment services within approved cost per person bands by the type of treatment	Services provided within cost bands
Use of Evidence-Based Practices	Use of Evidence-Based Practices <sup>2</sup>		Under Development	Total number of evidence-based programs and strategies

<sup>1</sup> For ATR, "Social Support of Recovery" is measured by client participation in voluntary recovery or self-help groups, as well as interaction with family and/or friends supportive of recovery.

<sup>2</sup> Required by 2003 OMB PART Review.



## Appendix C: CMS Quality Framework

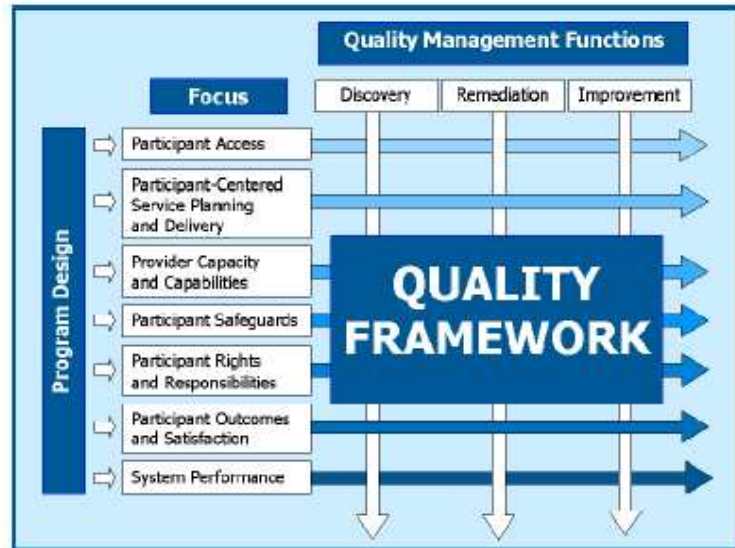
### HCBS QUALITY FRAMEWORK

The Home and Community-Based Services (HCBS) Quality Framework provides a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of community services and supports for older persons and individuals with disabilities. The Framework focuses attention on participant-centered desired outcomes along seven dimensions.

Program design sets the stage for achieving these desired outcomes. Program design addresses such topics as service standards, provider qualifications, assessment, service planning, monitoring participant health and welfare, and critical safeguards (e.g., incident reporting and management systems).

Quality management encompasses three functions:

- **Discovery:** Collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement.
- **Remediation:** Taking action to remedy specific problems or concerns that arise.
- **Continuous Improvement:** Utilizing data and quality information to engage in actions that lead to continuous improvement in the HCBS program.



Focus	Desired Outcome
Participant Access	Individuals have access to home and community-based services and supports in their communities.
Participant-Centered Service Planning and Delivery	Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.
Provider Capacity and Capabilities	There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.
Participant Safeguards	Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
Participant Rights and Responsibilities	Participants receive support to exercise their rights and in accepting personal responsibilities.
Participant Outcomes and Satisfaction	Participants are satisfied with their services and achieve desired outcomes.
System Performance	The system supports participants efficiently and effectively and constantly strives to improve quality.

Quality management gauges the effectiveness and functionality of program design and pinpoints where attention should be devoted to secure improved outcomes.

Program design features and quality management strategies will vary from program to program, depending on the nature of the program's target population, the program's size and the services that it offers, its relationship to other public programs, and additional factors.

The Framework was developed in partnership with the National Associations of State Directors of Developmental Disabilities Services, State Units on Aging, and State Medicaid Directors.



## Appendix D: Description of Data Sources

### Domain 1: Access To Services

Table 1.1.a Persons in Need (*Prevalence Rates*): The estimates of the percentage of individuals who experience a mental health, developmental, and/or substance abuse disability each year come from the following sources:

**MH Prevalence Rates:** Prepared by NRI/SDICC for CMHS, June 14, 2008 (for the MH Block Grant)

- Children: URS Table 1: Children with Serious Emotional Disturbance, ages 9-17, by State, 2007. Note: 12% is the midpoint (11%-13%) for the LOF=60 range (SED with substantial functional impairment). The same rate was applied to children under age 9.
- Adults: URS Table 1: Number of Persons with Serious Mental Illness, age 18 and older, by State, 2007.

**NC Substance Abuse Prevalence Rates:** SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2005 and 2006, published Feb 2008.

- Children and Adults: Table B.20, Dependence on or Abuse of Illicit Drugs or Alcohol in Past Year, by Age Group and State: Percentages, Annual Averages Based on 2005 and 2006 NSDUH.
- Prevalence rate for adolescents (ages 12-17) is 7.83%, for adults (ages 18-25) is 18.87%, and for adults (ages 26+) is 6.84%. Total = 8.45%. Applying these age group rates to July 2008 population = 8.62% total.

**DD Prevalence Rates:** Report by the US DHHS, Surgeon General (2001) based on data from the 1994 and 1995 National Health Interview Survey (NHIS) Disability Supplement, Phase I, Estimated Ages of People with MR/DD in US Non-Institutional Population. Prevalence rates for persons ages 3-5 = 3.8%, ages 6-16 = 3.2%, ages 17-24 = 1.5%, ages 25-34 = 0.9%, ages 35-44 = 0.8%, ages 45-54 = 0.7%, ages 55-64 = 0.5%, ages 65+ = 0.4%. The corresponding numbers of North Carolina residents in need in each age-disability group are calculated using US Census data for the relevant populations as of July 2007.

Table 1.1.a and Table 1.1.b Percent of Persons in Need and Served (*Treated Prevalence*): The percent of persons in need who receive services is calculated by dividing the number of persons who received at least one Medicaid or state-funded service (based on paid claims in the Integrated Payment Reimbursement System (IPRS) and/or Medicaid claims system for the time period July 1, 2007 through July 30, 2008) by the number of persons in need of services. The number of persons in need (the denominator) includes North Carolinians that the state's MH/DD/SA service system is responsible for serving (ages 3 and over for MH and DD, ages 12 and over for SA). The disability of the consumer is based on the diagnosis reported on the service claim. Persons with multiple disabilities are included in all relevant groups. Persons served in Piedmont LME are not included.

Table 1.2.a Percentage of Persons Receiving Timely Access to Care: This measure is calculated by dividing the number of persons requesting routine (non-urgent) care into the number who received a service within the required time period (7 days in CY 2007 and 14 days in CY 2008) and multiplying the result by 100. The information comes from data submitted by LMEs to the Division. The Division verifies the accuracy of the information through annual on-site sampling of records. Currently, this information is being published in the quarterly *Community Systems Progress Report*. More information



on this report can be found on the web at:

<http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm>.

**Table 1.2.b Service Met in Time Frame that Met Needs of Consumers:** The data presented in these tables come from clinician-to-consumer initial interviews that occurred between July 1, 2007 and June 30, 2008 through the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS). This web-based system collects information on a regular schedule from all persons ages 6 and over who receive mental health and substance abuse services. More information on NC-TOPPS, including annual reports on each age-disability group, can be found at <http://nctopps.ncdmh.net/>. The interviews included 32,502 adult MH consumers, 14,508 adolescent MH consumers, 12,865 child MH consumers, 16,782 adult SA consumers, and 1,561 adolescent SA consumers. Notes about the data: Private methadone consumers are not included. Within age groups, mental health and substance abuse consumers overlap due to co-occurring disabilities.

## **Domain 2: Individualized Planning and Supports**

**Tables 2.1.a Choice Among Persons With Mental Health And Substance Abuse Disabilities:** This information comes from NC-TOPPS, described in Table 1.2.b above.

**Tables 2.1.b Control Over Daily Decisions for Persons With Developmental Disabilities:** The data presented in these tables are from in-person interviews with North Carolina consumers in project year 2006-07, as part of the National Core Indicators Project (NCIP). This project collects data on the perceptions of individuals with developmental disabilities and their parents and guardians. Approximately 500 in-person interviews with consumers are conducted each year. In addition, over 2,000 mail surveys are sent out each year to parents and guardians of individuals receiving developmental disability services and supports. The interviews and surveys ask questions about service experiences and outcomes of individuals and their families. More information on the NCIP, including reports comparing North Carolina to other participating states on other measures, can be found at: <http://www.hsri.org/nci/index.asp?id=reports>.

**Tables 2.2.a Family Involvement for Consumers With Mental Health And Substance Abuse Disabilities:** This information comes from NC-TOPPS, described in Table 1.2.b above.

**Tables 2.2.b Input into Planning Services and Supports for Persons With Developmental Disabilities:** This information comes from NCIP, described in Tables 2.1.b above.

## **Domain 3: Promotion of Best Practices**

**Tables 3.1.a – 3.1.c Providers of Evidence-Based and Best Practices:** Information on numbers served in certain services comes from claims data, as reported to Medicaid and the Integrated Payment and Reimbursement System (IPRS).

**Table 3.2.a Short Term Care in State Psychiatric Hospitals:** The data come from the Division's Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) HEARTS discharges for the period July 1 - December 31, 2007. The HEARTS data include demographic, diagnostic, length of stay and treatment information on all consumers who are served in State-operated facilities. Lengths of stay are calculated by subtracting the date of admission from the date of discharge. The percents for each length of stay grouping (1-7 days, 8-30 days, and over 30 days) are calculated by dividing the total number of discharges during July 1-December 31, 2007 into the number of discharges in each length of stay grouping and multiplying by 100.

Table 3.2.b Admissions to ADATC Facilities: These data come from the Division's HEARTS data for July 2006 through December 2008.

Table 3.3.a Follow-up Care for Consumers Discharged from ADATCs and State Psychiatric Hospitals: The data come from HEARTS direct discharges during the period April 1 - June 30, 2007 and Medicaid and State Service Claims data for April 1- December 31, 2007. Data from Piedmont LME are not included. Discharges to other state-operated facilities and the criminal justice system are not included. The time between discharge and follow-up care is calculated by subtracting the date of discharge from the date of the first claim for community-based service that occurs after the discharge date. The percents of persons seen within 7 days, 8-30 days, 30-60 days, and greater than 60 days are calculated by dividing the total number discharged during the period into the number in each of the groupings of time to follow-up care.

Table 3.3.b Follow-up Care for Consumers Discharged from State Developmental Centers: These data come from reports submitted quarterly by the developmental centers to the Division. The numbers do not include persons discharged from specialty programs (such as programs for persons with both mental retardation and mental illness) or persons who were discharged after receiving respite care only.

#### **Domain 4: Consumer Outcomes**

Tables 4.1 Service Outcomes For Persons With Developmental Disabilities: This information comes from NCIP, described in Tables 2.1.b above.

Tables 4.2 and 4.3 Service Outcomes for Individuals With Mental Health And Substance Abuse Disabilities: This information comes from NC-TOPPS, described in Table 1.2.b above.

#### **Domain 5: Quality Management**

Table 5.1.a and Table 5.1.b Assurance of Basic Service Quality: The information comes from the December 2008 *Monthly Report on Community Support Services*.

#### **Domain 6: Efficiency and Effectiveness**

Table 6.1 Effective Management of Information: The data for information management come from calculations of compliance for requirements in the DHHS-LME Performance Contract.

Table 6.2.a and Table 6.2.b and Table 6.2.c Percent of Funds Spent: The data for Table 6.2.a on expenditure of funds come from service claims submitted to the Integrated Payment and Reporting System (IPRS) between July 1 and December 31, 2008 by LMEs that are not single-stream funded. The data for Table 6.2.b and Table 6.2.c on shadow claim submissions come from service claims submitted to the IPRS by LMEs with single-stream funding between July 1 and December 31, 2008. Submitted claims that are reimbursed with federal funds on a unit-cost basis or denied due to lack of funds (a fiscal denial) are included in the numerator, along with federal funds paid on an expense basis. The denominator includes total annual allocations, excluding funds for LME system management and funds received from the Mental Health Trust Fund.